IN THE COURT OF COMMON PLEAS
TRUMBULL COUNTY, OHIO

STATE OF OHIO,	:	
Plaintiff,	:	Case No. 01-CR-794
-vs-	:	
NATHANIEL JACKSON,	:	
Defendant.	:	

VOLUME II, EXHIBITS TO NATHANIEL JACKSON'S AMENDED POST-CONVICTION PETITION

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Sensitive Material – Discretion is Necessary

PSYCHOLOGICAL REPORT

SUBJECT: Nathaniel Jackson DATE: 11/12/02

REASON FOR REFERRAL:

Mr. Jackson was evaluated as part of developing information relevant to the mitigation phase of his capital murder trial.

PROCEDURE:

Interviews of Mr. Jackson by S. McPherson and D. McPherson; psychological assessment administered by D. McPherson, M.Ed., assisting psychologist: Thematic Apperception Test, WAIS-3, MMPI-2, WRAT-3, and Bender Gestalt. Rorschach administered by S. McPherson. Review of records from discovery and from other sources. Contact with family members.

RESULTS

Defendant's Retrospective on His Own History:

He was asked to discuss his life in stages. When asked about his first five years, he said that his maternal grandmother was very important to him, as was his mother. He had an older brother, Charles, and a younger sister and brother, Taushia and Anthony, respectively. He did not have very much contact with his biological father (Charles Paige), remembering perhaps two times when he saw the man. He lived with his mother, and he frequently spent time with his maternal grandmother. (Other records indicated the two younger children were the product of his mother's marriage to Anthony Kornegeay.)

With respect to his elementary school years, he said that he tried to do his best and in many ways he really liked school, but he also got into a lot of difficulty and tended to have problems with other students at times. He knew that he had been identified as having a behavior problem, and he stated that when he was placed in the Stambaugh School Special Program he did best. Interestingly, he remembered being taken out of that program after he had apparently done somewhat well and put back into the mainstream curriculum with the result that he immediately got into trouble again and was put back in

EXHIBIT 61

Stambaugh's Special Program where, at least per his recollection, he did better once again. He left school at the age of 17 while he was still in the 11th grade.

From that time onward, his life involved basically living on the street in what was a crime-ridden and violent environment. He did have some regular jobs from time to time, but none of them were high paying. His drug use (see below) was also a part of his problem. He began getting into trouble almost immediately upon moving out from his mother's house.

He had a series of relationships, and he began getting into more and more trouble of a legal type (see below). Throughout the ensuing years, he had several relationships, one with the mother of his daughter, now age seven. That individual is now married, but he has tried to have some contacts with his daughter. He also has a son who would now be four years of age. He has had no contact with that child whose life has been a somewhat tragic story in and of itself. The child was born to Mr. Jackson and his then significant other. Shortly after birth, the child had a stroke and went into some seizures and was life-flighted to Rainbow Babies' & Children's Hospital. Over an ensuing period of time, the youngster was stabilized and diagnosed upon exit as having cerebral palsy. To the best of his knowledge, the child continues to be wheelchair bound or in a brace with limited ability. Subsequently, the relationship broke up, and the mother of the child placed the youngster with her mother, essentially abandoning him. When Mr. Jackson tried to visit his son, the maternal grandmother obtained a Restraining Order, and he has never been allowed to see him since.

Mr. Jackson indicated he grew up in an extremely violent neighborhood. (Consistently, there is the letter in the school records from his mother indicating that he should be given an excused absence because a man and a woman had been shooting at him.) After he left his mother's home, he was still primarily living on the street and in a neighborhood of significantly antisocial and violent people. He himself was shot four or five times. He indicated that for the most part, he had not obtained any hospital or medical attention for these events; in fact, he said he carried a bullet in his torso somewhere which causes him periodic difficulty. He sometimes more or less freezes and is unable to move until the spasm passes. He has been shot in the left arm, elbow, and head, all of these wounds involving grazing injuries. In addition, he indicated that he had a significant relationship with a woman and, in fact, was considering a permanent union when she was killed. She was apparently involved in some type of merchandising occupation and was killed by someone who wished not to pay for the merchandise obtained from her. Mr. Jackson also recounted that there was an occasion in which he left some clothes at the home of a person whom he viewed as a friend and with whom he had stayed briefly. When he returned to get his clothing, that individual confronted him with a gun and was not willing to give Mr. Jackson his clothes. He noted that he had a particularly nice set of outfits at the time. He felt the man's turning on him was a major wrong because he had trusted him and viewed him as a friend.

The relationship that he had with Donna was one where he thought he would avoid the problems he had had with some of the younger women with whom he engaged. He acknowledged that Donna was significantly older than he. He said that he thought perhaps it would work out better because she would be more stable and more able to provide responsibly for him. He said that she indicated to him that she was divorced in 1985 and that her ex-husband, though he now lived with her, was not romantically involved with her.

Test Results:

Results from the WAIS-3 were as follows:

Vocabulary	5	Picture Completion	8
Similarities	5	Digit Symbol-Coding	6
Arithmetic	5	Block Design	7
Digit Span	12	Matrix Reasoning	13
Information	5	Picture Arrangement	10
Comprehension	5		
Verbal IQ	82	Performance IQ	89

Full Scale IQ – 84

Above results showed significant variation among the subtests but overall performance, given test bias factors and educational deficit, reflected low average or better capacity. Deficit areas would be consistent with longstanding learning problems.

Results from the Bender-Gestalt showed no significant deficits of performance. There were some distortions and inadequacies that appear to be reflective of some lack of investment in performance.

Results from the Wide Range Achievement Test – 3 were as follows:

	Raw Score	Std. Score	%tile	Grade Score	Absolute Score
Reading	36	75	5	5	503
Spelling	43	103	58	HS	524
Arithmetic	46	111	77	HS	532

Above results reflected significant relative deficit in reading skills.

Results from the MMPI-2 indicated a need to present well and to overstate virtues. At the same time, there was a tendency toward some endorsement of symptoms that suggested an over-presentation of pathology. The overall handling of the test was inconsistent at times and interpretation, therefore, has to be somewhat guarded. What can be stated, however, is that there was neither a consistent attempt to look bad nor a consistent attempt to overstate positives. The main scale profile did not show over-statement of pathology. There was a spike 4 configuration that reflects endorsement of antisocial attitudes and/or impulsive behaviors. He showed concerns and anxiety about his current situation and the likely outcome. There were also some problems when it came to storing of angry feeling and he appeared to be an individual who can lose control because he has been storing and suppressing a lot of negative feeling without being aware of the degree to which he does so. Sub-scales reflected his sense that he is being pursued and persecuted, which is not inconsistent with his current reality situation and also that he feels a sense of alienation from his own functioning. He attempts to put on a facade of being in control and not caring what is happening but, in fact, there is an underlying significant apprehension. At the same time, he can affect a kind of cynicism which may mislead others to believe that he is in control of himself and the situation. Critical items include acknowledging misuse of alcohol and use of marijuana as well as endorsing that he has made mistakes in his life. There is some tendency toward blaming of others but it is not a pronounced assertion.

Projective tests provided some; insight into underlying personality characteristics and potentials. Analysis of thematic materials on the TAT indicated an individual who does not know how to go about managing life but who has incorporated that he should know better than he does. He has no real concept of how to proceed and there is no one available to provide him with guidance. Life tends to hand down punishment for bad behavior and he has learned to accept what happens but not to evaluate and plan to avoid negative consequences. He does not see much potential in the workplace, which is consistent with the reality of his environment. He cannot figure out how people fit into situations or what they are thinking. In effect, he is a poor reader of people even though he thinks he knows about them.

Results from the Rorschach, evaluated using the Exner protocol, indicated a valid and reliable record for interpretation. There were no indications of any serious mental health pathology, but rather he appears to be an individual who lacks the capacity to cope adequately with his environment. He tries to keep emotions at bay but doesn't have the wherewithal to do so and still adequately manage other and often pressing demands. He is rather constricted and limited in how he responds to others. The avoidance of processing emotional stimulation is extreme and suggests a defense in order to avoid feeling the painful affect that comes about when he lets himself be vulnerable to contacts by others. This feature is consistent with the history of behavioral deficit and lack of environmental support and effective intervention. There are underlying negative to self attitudes which he also tries to avoid directly experiencing. At the same time, there is self focus, a pattern associated with insecurity and neediness. He is significantly limited when it comes to dealing relationally as might be expected, and again his history has

involved difficulties that he has sought to remediate but has not the least idea as to how to handle. He tends to be guarded in how he approaches situations but the defensive stance means that he is not aware of all the aspects of the world that he needs to be in order to manage. He makes decisions on inadequate information and thus adds impulsivity of thinking to the existing disinhibitions that are part of the hyperactivity complex.

Legal History

His initial problems with the legal system occurred in his mid-teens when he did about six months in detention home. He had been charged in connection with driving violations and unruly behavior. He apparently was absenting himself from school. After he became an adult he worked at various jobs but did not have any regular or ongoing employment of any substance. He was incarcerated four times at Lorain Correctional as follows: 1/92 for aggravated burglary; 2/96 for having a weapon under disability (as a convicted felon he is not allowed to have a gun); 2/01 for charges in connection with a stole vehicle and stolen license plates. He apparently was briefly released but did not follow up appropriately while on parole and was returned to the facility and then released on 12/12, after which the crime took place. He was also arrested in connection with receiving stolen property, unauthorized use of a vehicle, and driving under suspension. According to the defendant and his counsel, during his time in prison he did not present as an adjustment problem.

School Records:

He did not complete the 11th grade and there was inconsistent attendance and involvement before he finally dropped out. He attended a number of different schools. School records indicated the following.

Behavioral problems were noted as of the 1st grade, or immediately upon his entry into a formal academic setting. Those behavior problems continued throughout the time that he was in school up through the 11th grade level, which was the point at which he left. By the 3rd grade, he had been suspended. He was finally assessed at the 4th grade level and found to have significant problems and to be in need of special educational assistance. At that time, His Wechsler Intelligence Scale results were: Verbal IQ, 72; Performance, IQ, 78; and, Full Scale IQ, 73. Interestingly, while he had below grade level achievement, he was not deficient at the level that the above score, particularly the Verbal one, might have suggested, particularly given that he was coming out of an environment that was not conducive to correcting or assisting him with his problems. However, consistent with the 4th grade results, in 1989 at the 10th grade level, he was tested with the Stanford-Binet and obtained an IQ of 70.

Other information from the school records indicated a pattern of absenteeism which tended to increase over the course of the year, a high potential for getting involved in altercations with peers, behavior problems on the bus and it was also noted as of the 9th grade that he was at high risk for chemical dependency.

Axis IV – Problems with primary support group, Problems related to social environment, Educational problems, Legal Problems.

Axis V – GAF = 40; major impairment in several areas of function

Summary:

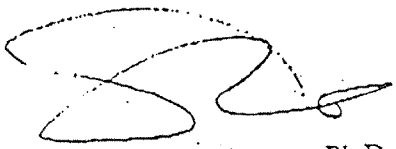
Mr. Jackson is an individual who was raised in an environment that was significantly violent and dyscontrolled that persons surviving in the situation would have been more likely than not to develop a sense of chronic threat and insecurity. Consistently, his own story is one where he has had to defend himself and where fights have not been infrequent, with fairly serious consequences to those participating. Early educational difficulties and current test results are consistent with the presence of an AD/HD component. The history of significant drug abuse starting at the age of 13 and probable dependency on marijuana is also a pattern that is well known for AD/HD persons. There is vulnerability to use, abuse and dependency on drugs to alleviate the chronic tensions and to escape the punishment that comes from the environment as a result of behavioral dyscontrol. Consistently, he chose not to abuse drugs such as methamphetamines or PCP. His use also reflected an occupational component in that he was living in a drug infested environment and, at least sometimes, involved in the lifestyle of using and selling. Given his educational limitations and social situation, obtaining employment with reasonable compensation in the depressed area in which he lived was unlikely.

His mother was on her own much of the time. Although he loves her and his grandmother, they were unable to intervene effectively with his special behavioral and learning needs. As time went on, the family system fragmented further. At the present time, his mother indicates she does not know the status of his sister and cannot be sure how to reach her. Similarly, she was unsure of the current situation of either of his brothers. She stated she works at a physically demanding job and has little energy except to go home and rest so as to be able to work the next day.

He had no male figure immediately available to him to provide him with alternative guidance from what was occurring as a function of his finding his own way in a hostile situation. There was thus no real functioning family system for him as he tried to deal with his needs for support. He does have the capacity to relate to other human beings, and it has been indicated in the records obtained that he has some artistic potentials.

His vulnerability to influence within the context of the relationship to Donna was high: she was older, apparently stable to his view, held out a promise of a more financially secure existence, and catered to his need to be seen as adequate.

He has been able to maintain himself in a stable fashion when he was prior incarcerated and, therefore, it can be reasonably inferred that he can be a productive member of the general population.



Sandra B. McPherson, Ph.D. ABPP
Clinical and Forensic Psychologist

IN THE UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF OHIO

WESTERN DIVISION

DAYTON

- - -

LAWRENCE LANDRUM, :

Plaintiff, :

Vs. : Case No. C-196-641

BETTY MITCHELL, : Thursday, 9:00 a.m.

Defendant. : September 4, 2003

- - -

EVIDENTIARY HEARING BEFORE

JUDGE MICHAEL R. MERZ

- - -

APPEARANCES:

FOR THE PLAINTIFF:

Gerald W. Simmons, Esq.

Randall L. Porter, Esq.

FOR THE DEFENDANT:

Jonathan R. Fulkerson, Esq.

Michael L. Collyer, Esq.

COURT REPORTER:

Shandy Ehde, RPR

person who did this terrible, terrible thing, you know.

Q. You indicated that at the time you did your work before the post-conviction process, that some of the records that you might have wanted to see had been destroyed or were missing. And I note that you were initially involved in the case in '91, you were asked to do the social history in '93, you completed the social history in '96. Do you have any idea why there was such a long delay between trial and post-conviction?

A. No. I mean every state is different in terms of how it moves cases.

THE COURT: You may step down.

THE WITNESS: Thank you.

(Witness was excused.)

THE COURT: Mr. Simmons, you may call your next witness.

MR. SIMMONS: Yes, your Honor. Dr. Smith.

ROBERT L. SMITH, Ph.D

witness herein, being first duly sworn, testified as follows:

DIRECT EXAMINATION

MR. SIMMONS: I think counsel has -- she's going to stay a while to hear the doctor's testimony.

THE COURT: Once she's testified, she has a right to be here.

BY MR. SIMMONS:

Q. Would you please tell the Court your name and address?

A. Robert Lee Smith, Ph.D. My address is 31470 St. Andrews Street, West Lake, Ohio.

Q. Would you please tell the Court what your practice entails?

A. Yes. I'm a clinical psychologist and a certified addiction specialist.

Q. What is the nature of the certification? Where does that come from?

A. The license in psychology is from the State of Ohio. Basically it comes as a result from having my doctorate from an APA approved from an academic program, and then I did an internship and post-doctorate internship in psychology and addiction. The certification addiction specialist is a national certification and is awarded once you're able to demonstrate appropriate educational and clinical experience.

Q. Have you had occasion to testify as an expert witness previously?

A. Yes, I have.

Q. Could you please tell the Court in general terms the quantity and nature of the testimony in which you've engaged?

A. I've probably testified in about 25 to 30 cases nationwide. Most of those have been either death penalty cases or appeals, but I've also worked in some civil litigation as well.

Q. And what is the nature of the testimony that you have generally given?

A. Generally what I've been asked to do is to conduct an evaluation of the defendant and determine whether or not there are any valid psychological diagnoses or disorders that could be presented to the court for mitigation.

Q. Could you please look at Exhibit 7?

A. (Witness complied.)

Q. What is Exhibit 7, please?

A. It's my curriculum vitae.

Q. Is it accurate and complete?

A. As far as I can tell it looks accurate, yes.

Q. Okay. Now there's a reference here to Behavior Management Associates, Inc, What is that?

A. It's a private practice group in which I'm one of the associates. I basically rent space from them and conduct a private practice in a suburb of Cleveland

with Behavior Management Associates.

Q. What is the nature of your private practice?

A. It's a clinical practice. I work with adults and adolescents. Basically a full range of psychological disorders as well as addictive disorders.

Q. What types of people do you deal with in your practice?

A. In my private practice, generally they will be men and women who have marital problems, occasionally will be individuals with depression and anxiety disorders. Most of the clients that have addictive disorders come because they are having difficulties maintaining abstinence. Most of them have a history of physical or sexual abuse that has not been adequately addressed so that interferes with their recovery.

Q. Do you do any clinical work in addition to your private practice?

A. Yes, I do.

Q. And tell the Court, please, what that involves.

A. I work as a director of operations for an organization called Stella Maris. Stella Maris is an alcohol and drug treatment facility in Cleveland. They have a 16-bed detoxification unit in a 42-bed therapeutic community. I began working with that

organization about four years ago.

Currently I'm a project director on a national federal grant. The goal of the grant is to conduct a research project. We're examining the treatment of homeless, chemically dependent and mentally ill male offenders. These men are referred through the court system in Cleveland. They're all homeless. They have a long-standing history of addiction, and about 60 percent of them have a co-curring mental illness. The treatment model that we have put together is, as a demonstration project, we're about a year and a half through the project. Our goal is to gather information about the effectiveness of the treatment and to hopefully come up with ideas and approaches that are more effective.

Q. Have you applied for, and have you received, any government grants in this area?

A. I have the current grant, and I also had a grant in 1993 with the Federal Government. Again the goal was to look at the treatment of homeless, chemically dependent women. The women who came into treatment were either pregnant or who had custody of one or two children. We developed a treatment design that allowed the women to come into treatment and bring their children with them. Again about 40 percent of

the women had a co-curring mental illness, and approximately 80 percent of them had a history of being physically and sexually abused.

Q. Have you done any work with the hospitals in the Cleveland area?

A. Yes, I have.

Q. And would you please tell the Court what that has involved?

A. Currently there's two primary hospitals that I have ongoing work with. I work with University Hospitals of Cleveland. I conduct a residency assistance program. If an intern or a medical resident has some type of personal problem, depression, anxiety, perhaps abuse of alcohol or drugs, marital difficulties, the university -- I mean the hospital will contact me. I'll do an assessment of the intern or resident, and then either do short-term therapy or link them to appropriate services.

I also work with Metro Health Medical Center, which used to be Cleveland Metropolitan General Hospital. I helped develop the employee assistance program when I worked there many years ago, and so what has happened is they have continued to keep me as a consultant even though I'm in private practice. So

I work with them on a weekly basis, looking at more difficult cases and helping the counselors sort of manage those cases.

Q. Have you done any lecturing in this field?

A. Yes, I have.

Q. And could you again tell the Court, please, what you have done in that regard?

A. The bulk of the research -- I mean the lecturing has been related to my research and clinical experience, and it's at Case Western Reserve University. I currently have an academic appointment with the department of psychology, and last year taught a course on mental illness and substance abuse, but I also have taught for the medical school and for the law school at Case.

Q. Have you done any continuing legal education for attorneys?

A. Yes, I have.

Q. And would you tell the Court, have you written any articles of any significance in this area that you think are pertinent to your experience?

A. I have several articles that we've published. Most of them have focused on identification and diagnosis of addiction, but we also have taken a look at the treatment of minorities and special

populations, and that's really where my research area is now.

Q. I take it that you have had an opportunity to review the work of Miss Miller, that is, the post-conviction work, the affidavit and the report that she did?

A. Yes, I did.

Q. And I take it you've also had a chance to review the court records of Mr. Landrum's trial, initial trial?

A. That's correct.

Q. Would you please look at Exhibit 4 and -- I'm sorry. John?

MR. FULKERSON: Before we proceed into the specifics on Mr. Landrum's case, I would like to clarify a few points on the witness' qualifications if this is the proper time to do that.

THE COURT: The voir dire may be allowed.

MR. FULKERSON: Thank you.

VOIR DIRE EXAMINATION

BY MR. FULKERSON:

Q. May it please the Court, counsel.

Dr. Smith, I'm Jonathan Fulkerson. We met briefly before we started. I want to ask you a couple questions about some of your qualifications before we

proceed this morning.

Do you have a board certification in psychology?

A. No, I do not.

Q. Are you a member of the, or do you know what the ABPP is; American Board of Professional Psychology?

A. Yes, I am aware of that.

Q. Are you a member of that organization?

A. No, I am not.

Q. You said on your initial testimony that you have a national certification as an addiction specialist?

A. That's correct.

Q. Where is that from?

A. I'm sorry, where is --

Q. Who gave you that certification; what organization?

A. The American Academy of Healthcare Providers and Addictive Disorders.

Q. Okay. And when did you obtain that certification? What year, do you remember?

A. No, I don't know offhand.

Q. Was it before 1996?

A. Yes.

Q. Okay. That organization's certification, you didn't have to take an exam to get that certification, did you?

A. No, I did not.
Q. And you were allowed to join without taking a national examination in order to get that certification; correct?
A. That's correct.
Q. Okay. You said that you do a lot of work as an associate with Behavior Management Associates?
A. I have a small private practice with them.
Q. Small practice. You do a lot of work with adults and adolescents that have addictive disorders; is that what you said? Am I correct?
A. Again based on Behavior Management Associates.
Q. I'm sorry, just talking about behavior management.
A. That's correct.
Q. You don't really deal with criminal assessments with Behavior Management Associates, do you?
A. Occasionally I will have a forensic evaluation through the organization, but that's a small part of my caseload there.
Q. But essentially Behavior Management Associates is kind of an employee assistance program; isn't that correct?
A. No, that's not correct.
Q. I want to have you refer to volume I of the

binder that I have provided to the Court and you, and I'd like to have you look at page 1 of that. And for your reference and the Court's, I've caused the bottom right corner of all these pages to be Bates stamped for convenience.

If I can ask you just to look at page 1, can you identify what that page and the preceding few pages are behind that?

A. Yes.

Q. What is that?

A. That's the employee assistance program that is the subset of what Behavior Management Associates does.

Q. And doesn't that say there that, "Behavior Management Associates provides complete program that addresses employee problems that include comprehensive work/life services and can be enhanced with ancillary service"?

A. That's correct.

Q. But it's not an employee service program?

A. You misunderstood my response. I said Behavior Management Associates is not an employee assistance program. This employee assistance program is called Impact, that's the employee assistance program. I have nothing to do with it.

Q. Thank you. Your CV also says you are a member of the College of Examiners?

A. That's correct.

Q. Are you a life member or yearly member of that organization?

A. I'm not sure of the distinction.

Q. Well, doesn't that organization -- there are two ways you can join. You can either join every year and pay every year or you can pay a larger fee and be a member for life?

A. I'm an annual member.

Q. Your are an annual member?

A. That's correct.

Q. Isn't it true to become a member of the organization you essentially self-certify yourself and agree to abide by their code of ethics to become a member?

A. That is part of it, correct.

Q. Is there an additional part of that that is required?

A. Yes. They now have testing. They also have continuing education requirements --

Q. Could you explain?

A. -- that are part of becoming certified.

Q. Okay.

MR. FULKERSON: That's all I have about his qualifications your Honor. Thank you.

THE COURT: You may resume your examination, Mr. Simmons.

FURTHER DIRECT EXAMINATION

BY MR. SIMMONS:

Q. Thank you, your Honor.

Dr. Smith, I'd like to ask you to please look at Exhibit 4 in the exhibit book.

A. (Witness complied.)

MR. SIMMONS: Just to keep things confusing, your Honor, it actually has an Exhibit 5 in the lower right-hand corner.

THE COURT: I'm going to mark that out on my copy.

THE CLERK: I'm restickering.

THE COURT: Thank you.

Q. Dr. Smith, have you, based upon your review of the records in the initial trial and your review of Miss Miller's work, and the other investigation you've done, formed some opinions about Mr. Landrum's psychological state at the time of the murder and also at the time of his trial?

A. That's correct.

Q. Could you please in a general way state to the

Court what you have, what these opinions are, and then we'll get into some specifics.

A. Sure. Basically I believe that at the time of the offense Mr. Landrum was dependent upon several chemicals. Alcohol, sedatives and cannabis, or marihuana. I also believe at the time of the offense that he was under the influence of alcohol and sedatives, that he was suffering from a psychological disorder that had been long standing from adolescence.

This depressive disorder is called dysthymia or disthymic disorder, and he as a child suffered a number of significant traumas and abuse that led to his development of depression and later his addiction to alcohol and other drugs.

THE COURT: Before we proceed, would you be gracious enough to spell dysthymia for the record?

THE WITNESS: D-y-s-t-h-y-m-i-a.

THE COURT: Thank you.

Q. And did this disorder that you have described have an impact on his cognitive abilities during this period of time?

A. Absolutely.

Q. And what was that?

A. In order to understand Mr. Landrum's function, you would have to take a look at all the disorders in

combination.

Disthymic disorder in and of itself has a number of influences upon both how a person feels, how they think and how they act. When a person has this type of chronic depression they often feel hopeless, helpless. There's a sense of agitation in their ability, low self-esteem, feeling they can't be successful, they can't do anything right. There's an underlying despair which leads to them to engaging in self-defeating behaviors.

Oftentimes they will attempt to do things, but because they believe they'll fail, they do. And so people with dysthymia have failed relationships, oftentimes are unable to maintain employment, and will turn to alcohol and drugs as a way of coping with this ongoing depression.

The use of alcohol and drugs of course changes the way the brain works. Alcohol is a central nervous system depressant. It slows down the brain, it results in impulsist mood swings, agitation, irritability, sometimes aggressive behavior. Mixing that with another drug, which Mr. Landrum did frequently, such as Ativan which is a sedative, in fact Ativan directly enhances the effects of alcohol so that it's not just an additive factor but

multi-flexitive factor, so that an individual taking alcohol and Ativan together will be significantly impaired in terms of their ability to focus, concentrate, interpret events that are going on around them.

Their motor movements may be, but it depends. People using with high tolerances, abusing substances for a long time, their body develops an ability to adapt to the effects of the chemicals, so they may be able to walk a straight line, they may be able to speak without slurring their words too badly. But in fact what's happening is their cognitive functioning is significantly impaired, just it's masked by their ability to walk and talk.

Putting the depression together with the effects of alcohol and the sedative, the individual's ability to comprehend a situation, concentrate, focus, consider their options, weigh the pros and cons, consider the consequences of their actions would all be significantly impaired.

Q. Was there any effort in the mitigation phase of this case to explain, for example, the relationships that you've just discussed between various drugs and alcohol?

A. I did not see any attempt to make that connection

explanation.

Q. Was there any discussion of any relationship between Mr. Landrum's depression or this disorder that you've described and his use of these substances?

A. Not that I'm aware of.

Q. In working with -- in coming to your conclusions, could you tell the Court what events or what history of Mr. Landrum, what events in his life to you were significant in coming to your opinions, and in particular if, while you're doing it, you could mention which of those, if any, were not dealt with in the original trial?

A. Yes.

Q. Just sort of go through his life, the significance of the various events and explain whether they were or were not dealt with in your view properly or at all at the original trial.

A. Okay. As a beginning statement, I think I would say that most of what I'm going to say I do not feel was adequately developed and discussed in the original trial.

What I'm looking at when I look at Mr. Landrum's background is a developmental history. I'm looking at how do these events impact the development of the child, how does that child cope with those events,

what is their response, what choices do they have available to them, what disorders may they develop, how do those developed disorders then affect ongoing sort of maturation and life choices, and then how, ultimately, did all of those things impact Mr. Landrum's behavior at the time of the offense.

I don't believe that the initial trial did much of that at all. I can kind of walk through these.

First things to become important are the absence of a father. For the first four years Mr. Landrum has no father figure that's present. His mother is somewhat present, but because of her schooling and work and because of the home environment, her involvement with Mr. Landrum was also limited.

THE COURT: What about the maternal grandfather?

THE WITNESS: We do have a maternal grandfather. Now he becomes very significant because he uses alcohol, and it's not every day but it is regular and it's excessive, and when he drinks to excess, he's abusive. Now that becomes important because Larry's going to be forming some opinions about the use of alcohol and what is appropriate behavior when you drink. His grandfather uses

regularly, becomes out of control, becomes violent. That becomes a socially acceptable behavior in some ways.

A. Then we have maternal aunts and uncles who also abuse alcohol and drugs. Now there's a couple ways to look at it, and I'm going to kind of talk about the development for Larry in several areas. If we want to look at his development of addiction, there are three things that put a child at risk for addiction. Genetic factors, environmental factors and psychological factors.

In Larry's family, we have genetic factors, we have a maternal grandfather who abuses alcohol and drugs, and we have maternal aunts and uncles, so we know there's a family history of substance abuse.

THE COURT: We don't know. Of course we know there's a family history. We don't have any determined, clinically determined patterns of tracing that genetic occurrence, do we have, in the matter of available science?

THE WITNESS: What the literature has shown us, if you have immediate family members, defined as parents, grandparents, aunts and uncles, if you have a significant history of substance abuse, the children are predisposed. It's not a direct genetic

inheritance but a predisposition, sort of like with cancer, so that children who come from a family history where there's cancer, we know that they're at risk. That's what we really know about the children.

The literature is suggesting that it's five times greater risk than for children who do not have a significant family history. But that's only one of the factors.

A. The second factor becomes environment. Children who grow up in a home where alcohol and drugs are readily available and where the parental figures or adult figures use alcohol and drugs are more likely to experiment and use drugs than their peers. What we have is, we have a grandfather, we have the aunts and uncles, later we have the stepfather, all who use alcohol and/or drugs on a regular basis, and that's part of family life. So that is another factor that contributes to it being okay to Larry to begin experimenting with alcohol and drugs.

The final factor is that we know that children who suffer physical abuse or sexual abuse are much more likely to begin using alcohol and drugs as adolescents. When we look at Larry's background, we have sexual abuse at the age of five. We have physical abuse by the stepfather over a number of

years. And we have numerous losses, the death of his grandmother, that he now is trying to cope with.

As a result, what we have is all three factors contributing to Larry's use of alcohol and drugs. It wasn't just one factor, but all three.

The other thing you begin to look at is, well, what makes something traumatic for a child? Why should these events have an impact on Larry? We've got dad out of the picture, we've got mom who is preoccupied, and then we've got the death of grandmother. We've got physical and sexual abuse. We've got the stepfather. Why should all those be significant?

Well, what we know from the research now is there are a number of things you can look at. One is to what extent is the event something that normally occurs in childhood. If it's a normal event, the child should be able to talk to friends, family and others, and work it through. It's not something that's strange or odd or something they should be embarrassed or ashamed about. The problem is that a number of things that happened in Larry's background were not normal events. Being sexually abused at the age of four and five is not a normal event for a child.

THE COURT: How abnormal is it, ideologically speaking, do you know?

THE WITNESS: In terms of percentages we're probably looking at less than three percent of the population overall experiences sexual abuse at the age of four or five. We do know that for females, adolescence is a more likely period for sexual abuse to occur.

A. The other thing that becomes significant is the age and the mental status of the victim when the trauma occurs. The less capable they are to process what happened to them, to talk about it, verbalize it and work it through, the more they're going to be traumatized by the event. So the age becomes significant, the level of maturity, the intellectual functioning are all factors.

Many of these events that occurred in Larry's life, he was very young, did not have the mental capability and the maturity to be able to work it through.

The next thing becomes how many traumas you have occur in your life. A single trauma can leave a lasting scar throughout a person's life, but multiple trauma becomes significant, because trauma basically tells me the world is a dangerous place and I have to

be very cautious, in fact maybe I need to even be aggressive to keep myself safe. If I have repeated trauma, that just keeps reinforcing to me that the world is dangerous and that life is filled with all sorts of hurt and pain and loss.

The last thing has to do with the recovery environment when a child has gone through repeated trauma. How supportive, how nurturing, how aware of the trauma are the family members, the parents with the child? Do they talk about it, do they work it through, do they get the child counseling and assistance for those disorders?

When we look at Larry's childhood there just wasn't the type of recovery environment to help him work through the traumas that he went through which again then contributes to his turning to alcohol and drugs as a way to sort of medicate himself and deal with his emotional pain.

Q. You have discussed the family situation as a young child, and I just wanted to be sure that you had, you feel you fully explored that. Have you discussed the situation in Sault Ste. Marie until he moved to the fullest you think appropriate?

A. Well, I think the other part that I would want to add is dysthymia is a chronic underlying depression

that oftentimes begins in the early adolescence and can persistent for many years. It is somewhat biologically based, but what we have been able to discover is that ongoing trauma tends to be one of the contributing factors to a person developing this kind of depression. That sense of helplessness and hopelessness, the inability to correct my situation, make my life better, that I continually seem to fail, no matter what I do I can't seem to make my life right becomes an underlying theme, and so that then builds into a depressive state that persists into adulthood.

Q. Is there any significance to your view in the remarriage of Mr. Landrum's mother and the move to Chillicothe in this analysis?

THE COURT: I think technically we're not talking about a remarriage. I think we're talking about a first marriage.

MR. SIMMONS: I think we are. Excuse me. Marriage.

A. The marriage becomes significant in several ways. First, mother moves and lives with in-laws, which allows Larry to be alone without his mother for about a month, which when you're looking at the age that he's at, is pretty traumatic. Even though the mother was not necessarily the best mother and always

present, she was there. Now she's completely absent.

Then after about a four- to six-week period, the mother removes Larry from his family completely, moves to another city, and now he's not able to see his grandparents, aunts, uncles, cousins. He's completely removed from them. And then lastly he's now adapting to this parental figure who is rather stern, has bouts of rage and abuses alcohol, and then at a later point discovers that this in fact is not his father but is his stepfather.

So there were a number of events that occurred in that transition that contributed to Larry's feelings again of loss, depression and attitudes about the use of alcohol.

Q. Is there any significance to Larry's experiences in his teenage years at either Upham Hall, the Fairfield School or elsewhere that you think fit into this analysis?

A. Yes. I think the records, particularly at Upham Hall, provided significant data regarding Larry's function at age 16. At that point he had overdosed on drugs, which clearly tells us at that point that his use of alcohol and drugs had already progressed to a point where it was causing significant problems in his life.

The records repeatedly document his feeling sad and presenting with symptoms of depression, and the problems with the stepfather's violent temper, and that that needed to be addressed and needed to be treated.

Unfortunately, it was not treated. The stepfather opted to not get counseling or therapy for himself. Larry did not want to go home. He had asked to go live with relatives in Michigan. The family, the mother and father, stepfather, decided not to allow that, that Larry needed to come back home.

Things did not go well when he went back home. He was violated for his probation, went to Fairfield School, and again removed from the family. He did fairly well. His grades improved in school, his behavior was appropriate.

What we find is that his behavior deteriorated from the point that his grandmother died, his mother married his stepfather, and the physical abuse began. You can see this progression. Progression in terms of alcohol and drug use, progression in terms of depression, progression in terms of behavior that becomes more and more erratic and out of control and unpredictable.

THE COURT: Meaning his behavior, not his

stepfather's?

THE WITNESS: No. Meaning Larry's behavior. The overdose when he's in the military. His behavior becomes out of control. At times he's AWOL for days at a time. He's not able to maintain his life in an orderly fashion because of the depression and the effects of the alcohol and drugs.

Q. Did you perform any tests or ask Mr. Landrum to undergo any testing in terms of your analysis of his situation?

A. Yes, I did.

Q. And could you please explain to the Court what testing you did and what, if any, significance it has on your overall opinion?

A. I basically did four things. I conducted the Michigan Alcoholism Screening Test. This is a screening instrument to look at an individual's use of alcohol. A score of 5 suggests the person has a problem with alcohol. Larry's score was 35.

I also administered the Drug Abuse Screening Test. This is used to screen for drugs other than alcohol. Again the cutoff score is 5 to indicate a problem, and Larry's score was 23.

These screening tools just simply reinforced what the records had shown and what my interview had

demonstrated, that Larry's use of alcohol and drugs was clearly a problem and was at a level to support a diagnosis of dependence.

Also I administered the Wechsler Adult Intelligence Scale to screen for intellectual functioning, found that Larry functions in the average range overall, or full scale IQ was 105. Then I also conducted the Minnesota Multiphasic Personality Inventory.

THE COURT: I or II?

THE WITNESS: II.

A. Basically it demonstrated that his clinical scales were all within normal limits. There were no significant elevations. The only sub-scale that was significantly elevated was the scale that's used to identify individuals who have a high susceptibility to abusing alcohol and drugs.

Q. Now you know there was some testimony at the trial, I think even in the mitigation phase --

THE COURT: I'm sorry, when were these tests administered?

THE WITNESS: The MAST and DAST were July 30th, 1993, and the WAIS and the MMPI were December 10th, 1993.

THE COURT: Thank you.

Q. Doctor, as you know, there were some references in the trial, and as I say, even in the mitigation phase that Larry drank too much. In your view is what you're saying just a repeating that kind of statement or is what you're saying something significantly different?

A. I think it's significantly different in that, yes, that is one of the symptoms that Larry had was that he drank too much. But more importantly, I think it's imperative that we understand that he had an underlying depression, that his use of alcohol and other drugs, not just alcohol, was a self-medicating approach to treating his depression and dealing with a number of early life traumas and ongoing losses throughout adolescence and into adulthood, he had a number of losses as an adult, and his way of coping was to use alcohol and drugs.

So that understanding that, I think we have a better understanding of why the alcohol was there and how the addiction developed, because once an addiction develops, then the individual, yes, they drink because of other factors, but they're also now drinking because they're addicted to the substance.

MR. SIMMONS: That's all I have, your Honor.

THE COURT: Thank you. Cross.

Let me ask, I suppose, Mr. Fulkerson, it being 10 minutes of 12:00, whether you anticipate a brief or extended cross-examination such that it would be appropriate to take the lunch break now?

MR. FULKERSON: I would think not more than 30 minutes at the most.

THE COURT: All right. We'll go ahead then.

MR. FULKERSON: Okay.

CROSS-EXAMINATION

BY MR. FULKERSON:

Q. Dr. Smith, when did you first become involved with this case?

A. I don't know the exact date. It was in the early part of 1994.

Q. And you became involved in the case through the Ohio Public Defender's Office?

A. That's correct.

Q. And were you paid for your services at that time to prepare the affidavit that is in the record in this case now?

A. For this affidavit? Yes.

Q. Correct. And how much were you paid for your services for the entire post-conviction process that you were involved in in this case?

A. I have no idea. I know what I charge per hour but I don't recall the total amount.

Q. What do you charge per hour?

A. A hundred seventy-five dollars per hour.

Q. Do you have any reasonable estimate of how many hours you put in to prepare the affidavit in your investigation for post-conviction?

A. Not at this point I don't.

Q. Okay. And you're also being paid for your services today?

A. That's correct.

Q. And you're charging $175 an hour?

A. No, it's $225 an hour for court time and testimony.

Q. It's been almost 10 years since your previous investigation. How were you contacted to testify in this proceeding?

A. Again I was contacted by the Ohio Public Defender's Office.

Q. That's fine. Do you support the death penalty?

A. Yes.

Q. Your CV says that you do some work with the Catholic Charity Services of Cuyahoga County?

A. I have in the past.

Q. Are you a practicing Catholic?

A. Yes, I am.
Q. And you have no opposition to the death penalty based on your religious beliefs?
A. No, I do not.
Q. Okay. Would you agree that it's not the role of your role in mitigation to make decisions about what strategies the trial counsel should employ?
A. I'm sorry, can you say that again?
Q. You testified on direct that your role is to present a valid diagnosis of somebody at the time of the crime and provide that to the defense?
A. That's correct.
Q. You would agree with me then that it's not your role to develop trial strategies, it's for a lawyer to do; correct?
A. That's correct.
Q. And you're not a lawyer?
A. No, I'm not.
Q. Would you agree then as a general matter that it's up to counsel to make the decision about what evidence to present in mitigation?
A. Yes. I just have one qualifier. Certainly when I'm asked by attorneys to do an evaluation, I will tell them records that I would like to review, individuals that I would like to interview, if I need

more time with the defendant, so that I want to give them a thorough evaluation so I will ask for those things. It would be their determination whether or not I receive them, but I will let them know what I need or what I at least feel I need to have a full and comprehensive assessment.

Q. Okay. In other words then is it important for you testifying in mitigation that you are presenting testimony that is consistent with the defense theory of the case?

A. That's their determination whether or not what I have is consistent with their theory, but what is important to me is that I have as much information as possible to feel confident that the opinions that I'm giving are valid.

Q. Do you know the defense strategy Mr. Landrum's attorneys used at trial, at the guilt phase of the trial?

A. Their strategy? I'm not sure.

Q. Do you know what their strategy was in the mitigation phase of Mr. Landrum's trial?

A. No, I'm not sure.

Q. You don't know then whether counsel's strategy was to admit Mr. Landrum's guilt or blame someone else for the crime or show that Mr. Landrum was remorseful?

A. No, I didn't work with the attorneys so I don't know their strategies.

Q. Of the people that you work with through Stella Maris and Behavior Management Associates and your work with Case Western, those are people that generally are seeking your help; is that a fair statement?

A. No.

Q. That's not a fair statement?

A. No.

Q. People are -- just come to you? How do they get to you for assistance?

A. I have several different groups that I work with. The Hitchcock Center for Women, probably 80 percent of those are coming on their own. Twenty percent are court-ordered treatment.

Q. So it's fair to say that some are coming to you really not of their own will, but because of the court direction?

A. Right. And then the men's program at Stella Maris is one hundred percent offenders, so they have a choice, the choice is to either go to prison or go to treatment. It's not exactly the same as choosing the treatment.

Q. I understand. Would you agree then that somebody in that situation might have a motive to fabricate

information to you as a clinician because they're under judicial pressure to do so? I don't mean judicial pressure but --

THE COURT: It is judicial pressure. That's right.

Q. Well, so would you agree with me that someone in that situation has a different motivation than someone who comes to you of their own free will seeking your help?

A. It can. It can be different.

Q. And when someone's not forthcoming with you about their background and personal information for whatever reason, that's corrupting your opinion; is that true?

A. It limits your opinion. It may not -- there may be sufficient additional sources or whatever that you can still draw a valid opinion, but it would be helpful if they're forthcoming and give you the information themselves.

Q. But when they're not giving you good data, your opinion is compromised as a result; is that correct?

A. Well, no. That's why I said no. I think again it depends on the number of other sources you have. If I have school records and medical records and psychiatric records and mother and father telling me something and the defendant doesn't necessarily

disclose that, that doesn't necessarily corrupt my opinion. What it means is I know what the defendant is telling me but I've got 12 other sources that say it's true.

Q. Do you remember testifying in the Mark Brown capital case?

A. No. Not necessarily, no.

Q. If I refer you to volume II of the book that I've provided, page 126 of that book, and again the page numbers are on the bottom right-hand corner of that.

A. (Witness complied.)

Q. I'll represent to you that that page is from your testimony in the Mark Brown capital case, and if I can refer you down to lines 17 through 20, could you just read that very briefly? Page 126, lines 17 through 20?

A. Yes.

Q. You were asked a question about whether someone is forthcoming with you or not corrupts your opinion and you answered correct?

A. That's true.

Q. Okay. I just wanted to clarify that.

Now you were talking a little bit about testing and interviews. Would you say as a general matter that it's important for you to personally interview

someone in a situation like Mr. Landrum before giving your opinion for mitigation purposes?

A. I think it depends upon the circumstances of the request by the attorneys so that I don't know that I can say yes or no to that. It's a very broad statement.

Q. Do you have to interview somebody to provide the opinions that you're providing?

A. It depends on what the circumstances are and what opinion they're asking for.

Q. If they're asking you to provide an opinion about someone's psychological diagnosis, do you have to interview them or is that just not necessary if you're given, let's say school records, medical records, test records, that kind of thing?

A. I think again it's an awkward question. If I was shown that the defendant had been given an IQ test four or five different times and all of the IQ's were the same, I would probably say there's not much reason to do a full assessment again. Why? We have a steady IQ, there's been no head trauma, the individual's verbal presents normal, I wouldn't see that. If we're trying to diagnose a very significant psychological disorder that may have been only developed recently, it would be important to be able to see them because

records may not necessarily reflect that.

Q. But you interviewed Mr. Landrum twice?

A. That's correct.

Q. At least in this case it was important for you to interview him?

A. Correct.

Q. And you also reviewed some of his school records?

A. That's correct.

Q. Would you say that's important to review in preparing your opinion?

A. Again I think that it's useful.

Q. Okay. Just to recap, you did do diagnostic interviews of Mr. Landrum; correct?

A. Yes.

Q. You gave him four tests which you've described, MMPI-II, the WAIS, you gave him the Michigan Alcoholism Screening Instrument and then the --

A. Drug Abuse Screening Test.

Q. Drug Abuse Screening Instrument. Did you do any other independent investigation on Mr. Landrum's case other than the tests you did and what was given to you in order to prepare your affidavit?

A. Review of records. (Witness nodded.)

Q. Did you review records not listed in your affidavit?

A. No, I did not.
Q. So you reviewed what was given to you by the defense?
A. That's correct.
Q. You didn't do any independent investigation on your own?
A. No, I did not.
Q. You didn't review any other reports or materials, again that were not given to you specifically?
A. The things I reviewed are in my affidavit.
Q. Okay. Let me talk a little bit about your affidavit and get into some specifics.
How many questions are on the Michigan Alcoholism Screening Test?
A. Approximately 28. Twenty-eight, I think.
Q. And the Drug Abuse Screening Test is 20 questions?
A. Twenty-eight as well.
THE COURT: Let me just ask a question about that while it's on my mind.
THE WITNESS: Sure.
THE COURT: If I want to take the MMPI or the Myers-Briggs for example, I have to take it with somebody who's got the right to administer it. What about the MAST. Is it on line?

THE WITNESS: The MAST is on line, you could get it as well as the DAST.

THE COURT: Go ahead.

Q. Looking at your affidavit, in paragraph 14 that you have in front of you there -- I'm sorry just want to back up one second. Paragraph 13. I believe that's on page 7 of your affidavit. In there, you talked about this on direct examination, you talked a lot about Mr. Landrum's background and family and how that affected him later in life. Is that fair to say?

A. Yes.

Q. Are you aware that the defense in mitigation tried to show that Mr. Landrum in fact had a good family background?

A. I know that when I reviewed the transcript, that there were statements that certain parts of his life were good, yes.

Q. Don't you think the testimony that you're proposing here today would conflict with what that trial strategy was, that he came from a good family?

A. Again I can't comment on trial strategy.

Q. Okay. You also testified fairly extensively about Mr. Landrum's addictive disorders and the effects on him. I'm going to get into that in a little more detail, but are you aware also that

defense argued in mitigation that Mr. Landrum did have a background with serious drug and alcohol abuse?

A. I know that they mentioned that he abused those substances, yes.

Q. Looking at paragraph 14 of your affidavit, and again you talked about this a little bit on direct, Mr. Landrum's time at the Fairfield School for Boys and his time that he was in the Navy. How long was he at the Fairfield School for Boys, do you know?

A. I don't recall offhand.

Q. It's fair to say from your review of those records that's a pretty structured environment, it's not an open school?

A. Very structured environment, yes.

Q. But he graduated; correct?

A. He completed that school and had very good grades there.

Q. Got good grades, got a diploma. Got a driver's license, too, didn't he?

A. That's correct.

Q. Is it fair to say that he did fairly well while he was there for a substantial period of time?

A. I thought that he did exceptionally well there. I was very pleased to see his response to a structured environment without alcohol and drugs.

Q. Let's talk a little bit more about the alcohol and drugs, and specifically at the time of the crime. Do you know how much Mr. Landrum weighed at the time of the crime?

A. Not offhand. I know that he's always been small in stature.

Q. Is it fair to say that your body mass and weight affects the ability, or affects how drugs and alcohol react within your body?

A. Yes. What we know is the smaller the individual, the less it requires for an individual to become intoxicated. So someone smaller in stature would require a smaller amount of actual drug in order to be impaired and intoxicated.

Q. But you're not sure what his body weight was at the time of the crime?

A. Not exactly. I mean I know that he was small in stature. That was documented throughout the medical records that he was always rather small, and with that in mind, the amount of alcohol, even if he had been a large person, based upon the transcript indicating that he had 12 to 18 beers and somewhere around six to eight Ativan would have been enough for a person who weighed 250 pounds to be grossly intoxicated.

Q. Okay. Your affidavit, also your direct testimony

was that you concluded influence of alcohol and sedatives was prominent in Mr. Landrum at the time of the crime; is that fair to say?

A. That's correct.

Q. Would that affect his memory of the events at that time?

A. Absolutely.

Q. Are you aware that Mr. Landrum testified at trial?

A. Yes, I am.

Q. Are you aware that he testified in some detail about going into Mr. White's apartment and what happened?

A. That's correct.

Q. It's fair to say he had a very clear memory of what's going on?

A. I don't know that at all.

Q. In fact, Landrum on cross-examination by the prosecutor said that he knew what he was doing and it was hard to forget what had happened. Did you read that part of the testimony?

A. Yes, I did.

Q. Mr. Landrum also testified about him and Mr., he and Mr. Swackhamer's drinking a case of beer. In fact you talked about this a little bit on direct, that he

had taken eight Ativans and had consumed approximately 14 to 18 beers before the crime. Landrum are you aware testified that he had been drinking beers about every five minutes before the crime?

A. Yes.

Q. Is that consistent with someone with the diagnoses that you provided?

A. Yes.

THE COURT: Hang on just a second.

Okay.

Q. Pretty fast drinker, isn't he? Drinking a beer every five minutes is a pretty fast drinker?

A. It's very fast for a social drinker. Again you have to think about a person who is a heavy drinker, an alcoholic. I have seen alcoholics to drink two cases of beer a day, fifth of whiskey and a case a beer a day, so no.

Q. Okay. I want to talk about paragraph 18 of your affidavit. I'm going to break this down just a little bit. You concluded within a reasonable degree of psychological certainty that he was dependent on alcohol, sedatives and cannabis at the time of the offense?

A. That's correct.

Q. And that he was under the influence of alcohol

and sedatives at the time of the offense?
A. That's correct.
Q. And I'm just reading from -- that he was suffering from a depression called dysthymic disorder?
A. Disthymic.
Q. Thank you. And that was exacerbated by the use of alcohol and sedatives, and that he was in a state of diminished capacity.
Are you aware that the State of Ohio doesn't recognize the defense of diminished capacity?
A. I think I've read that.
Q. Okay. Is it fair to say that your conclusion that Mr. Landrum didn't understand the situation and that his judgment was inappropriate is based on the -- Let me strike that. Start over again.
Mr. Landrum, in your opinion, did he know right from wrong at the time of the crime?
A. I believe that he knew that he was committing a robbery and that was going on.
Q. Do you believe that he knew that he was committing a murder? If he was committing murder would he know that he was doing it?
A. I don't know that there was deliberation to commit a murder so I don't know about that.
Q. But there was a lot of deliberation before the

murder; correct?

A. Well, there was to break into his home and to rob it. There was planning for that.

Q. In fact, there was a lot of planning. That's when he was intoxicated; right?

A. Again I don't know what a lot is, but I know there was planning and that occurred while he was using substances.

Q. We'll walk down it. He armed himself with a railroad bolt before he went there. He had the foresight to gather a weapon of some kind; correct?

A. I know that he had a railroad bolt, or someone did. I don't know that he brought that or who brought that.

Q. He and Mr. Swackhamer cased the apartment before they went there; right?

A. That's my understanding. (Witness nodded.)

Q. Okay. He had the foresight to wear surgical gloves during the burglary?

A. Correct.

Q. He told Carolyn Brown that he would kill the victim if the victim returned; right?

A. I've heard of that. I don't know about that.

Q. Well, the Ohio Supreme Court found that in their factual findings. Were you aware of that?

A. That could be.

Q. Okay. He waited for White to leave the apartment. You are aware of that?

A. Yes.

Q. He was given the -- When Mr. White returned, Mr. White, according to the Ohio Supreme Court said something along the lines of, what are you doing, get out of here, and Mr. Landrum didn't leave?

A. That's correct.

Q. So all those things kind of indicate some level of understanding of what's going on. Isn't that inconsistent with your opinion that he didn't understand the situation?

A. No.

Q. Despite the fact that he did all these things up to the time of the crime?

A. That's correct.

Q. What do you think would have been an appropriate judgment in that situation? You say Mr. Landrum didn't utilize appropriate judgment. What would have been appropriate judgment?

A. Well, again I think that what we're looking at is the difference between the ability to think and the ability to think in a logical and in a sort of higher order thinking. Certainly Mr. Landrum was thinking.

He's not unconscious, he's not mentally retarded, he's making a plan to do something, but doing it and doing it well are two different things. And clearly he waited for the victim to leave to rob the house and then everything went wrong from that point on.

I would suggest that had he not been depressed, not been under the influence of alcohol and drugs, that his response to the situation might have been much different.

Q. Do you think most people not having Mr. Landrum's condition that are in a situation where they're burglarizing an apartment, are surprised by the owner, wouldn't react in kind of a panicked kind of reaction?

A. I think that would be part of it, and I think adding alcohol and drugs to depression only makes it that much worse.

Q. Okay. You talk about his inability to comprehend the situation. What do you understand the situation to have been at the time Mr. White came back into the apartment?

A. I didn't say that he was unable. I said it was impaired.

Q. His ability to comprehend the situation was impaired?

A. Correct.

Q. What do you understand is the facts that actually took place when Mr. White was murdered?

A. Again I don't know all the facts because I don't have that in front of me at this point. But what I do know is the cognitive functioning of Mr. Landrum at the time, and it's one of those things where it's not really about something willful. If someone injects certain drugs, they have an effect. If someone has a psychiatric disorder, it has symptoms. And the problem with those things, they don't go away. They're persistent, they're present.

So a person with depression, those symptoms will be present. If you have injected these drugs, within a period of time they're going to have the effect they have. And so we know that his cognitive functioning must be impaired given what he injected only several hours prior to the offense.

MR. FULKERSON: If I can have just a moment?

THE COURT: Sure.

Q. You gave Mr. Landrum an MMPI; correct?

A. That's correct.

Q. And that was the second version?

A. Uh-huh.

Q. The court reporter is taking everything down.

A. Yes.

Q. Did you do a validity determination on the MMPI that you gave Mr. Landrum?

A. It has validity scales and reliability scales, and those indicated that the MMPI was both reliable and valid.

Q. Did anyone else review the MMPI that you gave Mr. Landrum? Has anyone else ever reviewed it?

A. I'm not aware anyone has.

Q. You have given MMPI tests to people in the past in this context, capital cases. Has anyone ever looked at your results and determined they were invalid, the test was invalid?

A. Looked at the test that I gave that I said was valid and then they found it to be invalid?

Q. Correct.

A. No.

Q. Okay. You didn't give Mr. Landrum a Symptom Checklist test, did you?

A. No, I did not.

Q. You didn't give him an Impact of Life Events test?

A. No.

Q. And you didn't give him a Millon Clinical Multiaxial test?

A. MCI. No, I did not.

Q. Do you need to give those tests to do a thorough examination in this context?

A. No. Many of those would be competitive and result in possible invalidity of the test.

Q. Did you diagnose Mr. Landrum with a social personality disorder?

A. No.

Q. Have you ever diagnosed anyone in a capital context with an antisocial disorder?

A. Absolutely.

Q. You have testified in several of these cases; correct?

A. Where I found them to be antisocial?

Q. Just in general, you have testified in several capital cases in this context?

A. Yes, I have.

Q. Would you characterize Mr. Landrum's family life growing up as dysfunctional?

A. Yes.

Q. Isn't it true that not everyone that comes from a dysfunctional family suffers from the kinds of disorders Mr. Landrum does?

A. I think the problem is taking the term dysfunctional and applying it to all families. Individuals who come from Mr. Landrum's dysfunctional

background will present with the symptoms that he has.
Q. Okay.
THE COURT: Unless he gets treatment, or regardless of whether he gets treatment?
THE WITNESS: It will depend upon the type of treatment. Part of the difficulty that I had as a professional was reviewing the Upham Hall records. It was very disappointing to see that they referred to his alcohol and drug abuse repeatedly, yet there was nothing in the treatment plan to address the alcohol and drug addiction.
Q. On the MMPI test that you gave Mr. Landrum, did you disregard any of the answers to any of his questions when you scored the test?
A. No.
Q. Have you ever given an MMPI where you have disregarded answers to questions before that didn't --
A. I'm not sure. Do you understand the MMPI?
Q. Let me ask this. Have you ever -- you have given MMPI's in other contexts; correct?
A. I have given MMPI's throughout my career. In fact my research is on the MMPI.
Q. In giving an MMPI test, have you ever looked at the results and thrown out questions that suggest things that are inconsistent with your diagnosis?

A. Absolutely not. That would be both unethical and inappropriate. In fact you can't even determine what questions are going to be used or not used. That's not the way the MMPI is scored.

Q. You're saying that you have never --

A. It's not based on individual items.

Q. Pick and chose?

A. The whole idea is that the MMPI is 76 or 77 items and it's based upon profiles, not on individual items. And taking items out, any items out based upon the clinician's determination, would be inappropriate. The only time that you ever look at items individually are what are called the critical items of the MMPI.

Q. What are critical items?

A. Critical items are items that suggest very severe pathology. Suicidal ideation, alcohol, drug addition.

MR. FULKERSON: Can I have just one moment, your Honor?

THE COURT: Of course.

MR. FULKERSON: Thanks.

Your Honor, there will be no further questions.

THE COURT: Redirect?

MR. SIMMONS: Yes, your Honor. Very briefly, I promise.

REDIRECT EXAMINATION

BY MR. SIMMONS:

Q. I just wanted to be sure if I haven't already covered this, Doctor. We have in this case as Exhibit 3 an affidavit of Jill Miller, which I'm sure you've seen, I know you've seen. And a confidential memorandum attached to it that she did and submitted as part of her post-conviction proceedings in state court. You are familiar with those?

A. Yes.

Q. Were those important documents for your analysis?

A. Those are very important. Oftentimes they are summaries affidavits that are provided regarding interviews that were done with family members and friends that I would then rely upon as additional data to corroborate or not corroborate opinions that I have.

Q. That's all I have.

THE COURT: Anything further based on that?

MR. FULKERSON: No, your Honor.

THE COURT: I have a couple things myself.

EXAMINATION

BY THE COURT:

Q. Maybe just one area. I think you've said that you believe that Mr. Landrum panicked when Mr. White

returned, and that that panic was exaggerated by the effect of the alcohol and Ativan that he had consumed. Did I hear you correctly?

A. I think that his response was not a logical response but was a reaction, not a thought-through action but a reaction to the situation that then was based upon an impaired mind that's been sedated by both alcohol and Ativan.

Q. Is it at all likely that a person in those circumstances when reacting would chose a pattern of action that he had proposed before?

A. That would be a possibility. I think that some of it has to do with -- what's going through my mind is that Mr. Landrum has no history of violence that we're aware of.

Q. No history of violence at all?

A. Right.

Q. The point I'm adverting to is his statement prior to the murder during the course of planning the robbery, that if Mr. White comes back, I'll kill him. He may have been rehearsing that in his head.

A. Again I wouldn't want to speculate about what was going on in his head. When people are intoxicated or sedated, thoughts tend to not be as logical and flow as smoothly as we would expect or anticipate, so that

oftentimes there's missing logic, there's missing, sort of sequential thinking. And again it's more reaction to an event rather than I'm thinking about.

Q. Right.

A. He denies saying this so I don't know.

Q. Right.

A. That statement, I'm not sure what it means.

Q. You may step down.

A. Okay. Thank you.

(Witness excused.)

THE COURT: I believe that concludes the testimony to be presented in this matter, and so the next question is briefing schedule.

MR. SIMMONS: Could we move to admit the exhibits, please?

THE COURT: Of course.

MR. COLLYER: Your Honor, just for the record, we're going to object to the exhibits to the extent there are witnesses they did not call and could have called for purposes of this hearing, and we would rely on Williams vs. Coyle for that. That is inadmissible. When the Court orders an evidentiary hearing even though these are exhibits admitted to the state court, if these witnesses are available then those affidavits and reports are

MR. WILLE: Thank you.

(Messrs. Lazarow and Mezibov conferred privately.)

MR. LAZAROW: No further questions, Your Honor.

THE COURT: Is this witness released?

MR. LAZAROW: Yes, Your Honor.

MR. WILLE: Yes, Your Honor.

THE COURT: Thank you very much, Mrs. Leahy.

(Witness excused.)

THE COURT: Call your next witness.

MR. MEZIBOV: Dr. Parran.

THE CLERK: Raise your right hand, please.

(Duly sworn by the Clerk.)

THE CLERK: Thank you. Please be seated.

THEODORE V. PARRAN, JR., M.D.

a witness herein, having previously been sworn, testified as follows:

DIRECT EXAMINATION

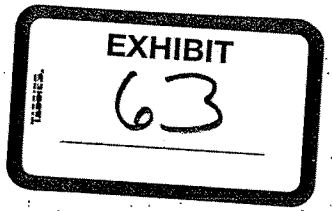
BY MR. MEZIBOV:

Q. Good morning, Dr. Parran.

A. Good morning.

Q. Dr. Parran, before I begin to ask you any questions, the first thing I would ask of you is that you state your full name and spell your last name for the record, please.

A. My that is Theodore Van Doran Parran -- P-a-r-r-a-n -- Junior.



Q. Dr. Parran, where do you reside?
A. I live in Shaker Heights, Ohio.
Q. And could you tell us your occupation, please?
A. I'm a physician.
Q. And a physician licensed to practice medicine in the State of Ohio?
A. In Ohio, yes.
Q. Dr. Parran, could you give us the benefit of your educational background?
A. I went to college at Kenyon College in Ohio, and then went to medical school at Case Western Reserve University, School of Medicine; graduated in 1982. I did my residency in internal medicine for three years at Johns Hopkins Hospital, in Baltimore City Hospital, in Baltimore, Maryland, and I spent an additional year as a medical chief residence there, so that is my formal education and training.
Q. And, Dr. Parran, could you give us the benefit of your professional experience as a physician since the time you graduated from medical school?
A. Yes, having graduated from medical school, as I mentioned I spent four years in residency training in Baltimore. I then spent another two years living in Baltimore working on the faculty at Johns Hopkins School of Medicine and helping to direct both the general internal medicine Clinic as well as a drug and alcohol treatment program in Baltimore City

Hospital. In 1988 I moved back -- I moved back to Cleveland, taking a faculty position at Case Western Reserve University School of Medicine in helping to direct both the general internal medicine Clinic and several drug and alcohol treatment programs and consultation programs in the Greater Cleveland area.

Q. And where are you employed at the present time?

A. Currently I'm employed part-time by Case Western Reserve School of Medicine as the Director of the Clinical Science Program as well as the Director of the Addiction Medicine Fellowship Program. I'm also employed part-time by the Cleveland V. A. Medical Center helping to -- as the Medical Director of their extensive Drug and Alcohol Treatment Program. And then finally I am part-time or privately employed as a member of a group practice of two of us providing addiction medicine services to hospitals and substance abuse treatment centers in Cleveland.

Q. How long have you been working at the V. A. at Cleveland?

A. I started working at the V. A. in 19 -- 1993. In 1993, we applied through the V. A. for a grant to support our addiction medicine fellowship program and that was funded as one of only six in the country, and have been employed part-time with the V.A. since then.

Q. Dr. Parran, over the course of time have you developed certain areas of specialization in the practice of medicine?

A. Yes, I'm board certified in internal medicine and I continue to practice, a small percentage of my time, in general internal medicine. I'm also certified by the American Society of Addiction Medicine in the area of drug and alcohol dependence and treatment. And I honestly spend the majority of my time working in the area of substance abuse treatment, as well as researching, education in the area of addictions.

Q. When you say "majority" of your time, could you assign a percentage of your time to that area of practice?

A. Probably 70 percent at this point.

Q. What is the American Society of Drug Addictions?

A. The American Society of Addiction --

Q. Addiction Medicine. I'm sorry.

A. Yes. It's a multi-disciplinary group of physicians, about 4,000, maybe 4500 members. Approximately 3,000 of us are certified --

Q. How do you become certified?

A. -- of the organization.

In order to be certified in addictions medicine, you have to be able to provide documentation that you have worked full-time in the area of drug and alcohol dependence treatment for at least two years, and then you have to take a certification examination.

Q. Now, you have treated, I take it, individuals who have

been addicted to alcohol or drugs?
A. Yes. Since -- since 1985, I've treated somewhere between 1200 and 3,000 patients a year, each year, with a history of addictions, approximately split 50/50 between alcohol dependent and drug dependent.
Q. Dr. Parran, in addition to the board certifications that you've told us about, are you a member of any professional boards or associations or organizations?
A. Yes, I'm a member, as I mentioned, of ASAM, the American Society of Addiction Medicine. I'm also a member and have in the past served on the board of the -- of an organization called AMERSA, which is the Association for Medical Education and Research in Substance Abuse. I'm a member of the Society for General Internal Medicine. I'm a fellow in the American College of Physicians. And I am a fellow and a member of the Executive Committee on the American Academy of Physician and Patient.
Q. Now, Dr. Parran, have you over the course of time published any books or writings or treatises or studies in your particular areas of specialization?
A. Yes, I have. I've written, oh, probably more than a dozen maybe, close to two dozen but at least a dozen papers, book chapters, syllabus modules on the treatment of addictions, screening for chemical dependency, screening for chemical dependence, how to present the diagnosis, how to

form a treatment plan with patients, management of detoxification and the acute effects of drugs and alcohol, syllabus materials on cocaine dependency, prescription drug abuse, et cetera.

Q. Finally, Dr. Parran, have you had occasion before today to testify in court in matters in which you are a specialist or in areas in which you practice?

A. Yes, I have. I've testified in both criminal and civil proceedings in the area of management of chemical dependency and/or addiction medicine, especially in the area of the management of acute drug induced delirium. That was a civil case. In the area of prescription drug abuse and stimulant abuse, especially diet pills, those have been criminal cases.

Q. And, Dr. Parran, at my request did you bring down to us today a copy of your current CV?

A. Yes.

(Mr. Mezibov distributing documents to the Court and counsel.)

Q. Dr. Parran, I've handed you what's been marked Plaintiff's Exhibit 14. Can you identify that for us, please?

A. Yes, it's my C.V. which was updated last summer.

Q. So this is current up through the summer of '96?

A. It's at least current through, oh, probably July of '96.

Q. Now, Dr. Parran, let's turn our attention to this matter

involving John Hicks. Could you tell us when you were first hired by myself and Mr. Lazarow in connection with this matter?

A. It probably was either late 1994 or early 1995.

Q. And do you recall what we asked you to do initially?

A. Yes, you asked me to look at the data about the case, especially the information that was gathered around the time of the events in early August of 1985, in order to form an opinion about whether or not cocaine played a role or appeared to have played a role in those events. And, secondly, you asked me to look at the trial proceedings and the testimony to see if I could form an opinion about the quality of the information there regarding the pharmacology of cocaine and how it might relate to this case.

Q. And, Dr. Parran, could you tell us how you went about conducting your evaluation in connection with these matters which we asked you to look into?

A. Yes. I read through a sort of summary or excerpts of both the police investigation, the police interviews, and then some of the testimony in terms of pretrial, trial and mitigation proceedings.

Q. Were you provided the actual trial transcripts then?

A. Yes. Yes. And I was able to look at some notes taken by Ms. Leahy. I was able to look at the affidavits of a couple of different physicians or a couple of different doctors. I

can give you the doctor's name if you want.
Q. Is that Dr. Baum?
A. Yes, Dr. Baum.
Q. And Julia Hawgood?
A. Hawgood, yes.
Q. Psychologist?
A. And I was able in July of 1995 to actually go in and interview Mr. Hicks. And, finally, I received the depositions of Dr. Schmidt --
Q. Schmidtgoessling?
A. 'Goessling, and Doctor -- starts with an R.
Q. Reardon?
A. Reardon.
Q. All right.
A. Yes.
Q. Could you tell us when you interviewed Mr. Hicks?
A. It was in July of 1995. I don't remember the exact date.
Q. Okay. And could you tell us approximately how much time you spent with Mr. Hicks?
A. About an hour-and-a-half.
Q. And what was the purpose of your speaking with Mr. Hicks?
A. I wanted to have a chance to talk with him both about his previous experiences with cocaine prior to the events of August of 1985, to speak with him about how cocaine tended to affect him when he was using it, to get at least his

recollections of that point in 1995 of what went on in August of 1985, and, finally, just to get my own sense of him and his mental status, perhaps psychological or psychiatric background. Although my background is in internal medicine and not in psychiatry or psychology, I spend lots of time interviewing people with issues in those areas and I wanted to get a chance to interview him myself about those kinds of things.

Q. Dr. Parran, when you were provided these materials -- the trial transcripts, the affidavits and depositions and then actually speaking with Mr. Hicks in person -- were there particular matters you were looking for in order to aid you in your evaluation?

A. I was looking for specific descriptions of his mind state, his thinking processes, his sensations when under the influence of cocaine both prior to August of '85 as well as in August of '85, and any descriptions or evidence from interviews that he had provided at that time that might give some evidence or some clue from a clinical standpoint to me as to what state he was in.

Q. At the time these offenses were committed?

A. Yes.

Q. Now, over the course of looking at these materials and speaking with Mr. Hicks, were you able to find any credible evidence of drug use or its effect in connection with

Mr. Hicks?

A. Yes, absolutely. His history that he provided to interviewers, provided to me as well, the history that his family members had been able to provide to interviewers, as well as some records from previously mandated court -- or court-mandated treatment from the chemical dependency standpoint, all indicated Mr. Hicks had had a significant addiction problem in the past.

Q. You used the term dependence, cocaine dependence. Can you tell us what that means from your standpoint?

A. Well, there's sort of an over-arching view or diagnosis we use of chemical dependency, which means the person meets a certain criteria in DSM-IV -- which is the Diagnostic and Statistical Manual-IV edition -- criteria for what would be called in the vernacular "addiction."

Chemical dependency -- in this case dependency to cocaine and alcohol -- includes: Compulsive use; use to levels of intoxication that weren't planned; adverse consequences from repetitive use; loss of control of use once initiating that use. So a person, as long as they haven't used any of the drug in a given day, tends to be fairly predictable; but when they do it again, they tend to lose control and over use, resulting in adverse consequences.

(Continuing) Increase in preoccupation with use; use despite repetitive and multiple, as I mentioned, adverse

consequences; sometimes increased tolerance, and at times physical dependence, including withdrawal from the drug when it's taken away -- although, I must say that 80 percent of people who meet the criteria for a diagnosis of chemical dependency or addiction don't have physical dependence to the drug, meaning they don't use it every day and they don't go through withdrawal when they stop using it.

Q. What you've just listed, are those objective signs and symptoms of chemical dependency?

A. Yes, they are objective. They're verifiable. They're primarily based on history. But a careful history taken from an individual can generally rule in or rule out chemical dependency.

Q. Did you find signs and symptoms of cocaine or chemical dependency in connection with Mr. Hicks?

A. Yes, absolutely.

Q. Can you describe to us what those objective signs and symptoms of chemical dependency was or were?

A. Yes. Mr. Hicks' background with alcohol and drug abuse -- primarily marijuana early on -- resulted in repetitive adverse consequences in his life from a performance standpoint in school, from a performance standpoint at work, from a financial standpoint, and from a legal standpoint from his late teens on.

He, during periods of less use or abstinence, tended to

function quite well, and at times of increasing use developed, as I mentioned, repetitive adverse consequences resulting in pain and suffering in his life as well as in those surrounding him.

Sometime in, the best of my recollection, the late '70s/early '80s, Mr. Hicks' drug of choice seemed to switch from alcohol and marijuana to cocaine and alcohol. And he developed, I think, inarguable evidence of cocaine addiction, including in 1982 or '83 going through a significant amount of money -- several thousand dollars that he had in a retirement fund -- in cocaine use, and actually in the year of 1985, earlier that year, going through probably a couple thousand dollars in his bank account and his wife's bank account for cocaine use. So that indicates cocaine dependence to me.

Another thing that indicates cocaine dependence is actually the way he tends to use. Initially, he started to use cocaine by snorting it, and fairly soon shifted to using I.V. And the data about cocaine use and the routes of administration indicates that of the 35 million Americans or so who have intermittently tried cocaine, there's about three million or three-and-a-half million, 10 percent, that develop cocaine addiction or cocaine dependence. And the vast majority of those who shift from intermittent use of cocaine, what might be casual use of cocaine and cocaine dependence,

tend to change their route of administration. They either use an I.V. or, more recently now, smoking the cocaine.

So, when I see a person who has a history of shifting their route of administration to an I.V. form, that is powerful evidence of a move to addiction.

And then, finally, the pattern with which he tended to use. He tended to use an intermittent binge pattern of cocaine. And, once again, people who are casual users or occasional users of cocaine tend to use it casually and occasionally. People who tend to lose control of cocaine, like most other stimulants that we have experienced with over the last hundred years or so, tend to shift to a pattern where they intermittently binge on the cocaine where they initially use it, and then use it several times to multiple times over the next few hours to few days until their money runs out, or they become too paranoid, or they become too exhausted, and then they sort of quit using the cocaine and crash and go to sleep and sleep off the binge. And it tends to be a -- sadly, sort of a payday phenomenon where people get paid on Friday and have strong urges and connect the use of cocaine with the handling of money, and then people tend to binge in the middle part of the week, recover on the weekend to go to work on Monday.

Q. What you describe, is that a phenomenon you observed or found in the history of Mr. Hicks?

A. Absolutely.
Q. Now, can an individual feign or fake cocaine dependency or chemical dependency?
A. No, not really. It's -- it's really not possible to fake addiction to the point of spending several thousand dollars of a retirement fund in a matter of several weeks to a couple of months intermittent binging on cocaine and then earlier in 1985 a couple of thousand dollars' worth of the entire bank account of oneself and one's spouse. That is just not a pattern that people are able to put on.
Q. What was the significance of this history that you found with regard to Mr. Hicks in your evaluation that we asked you to do for us?
A. Well, the history that I found with Mr. Hicks in terms of his shifting from marijuana to cocaine, people who have previously been dependent on marijuana -- which is a sort of a small scale or fairly weak stimulant on the dopamine system -- a person who's been a habitual dependent or addicted marijuana smoker, if they start using cocaine, tend to in a high percentage of cases, I would say 85 percent of the time, develop cocaine dependence, and it's certainly what happened to Mr. Hicks.
Q. You mentioned the dopamine phenomenon. What is that?
A. Uh-huh. Cocaine has three primary effects in the body, three primarily pharmacological effects. It's first effect

is to basically short circuit the peripheral nerves. It blocks the sodium potassium-pumping peripheral nerves and, therefore, it is a very good anesthetic, and cocaine is used as a local anesthetic. Since the peripheral nerves are short circuited, they can't transmit pain sensation and so they become deadened or numb, the area where it's applied.

The second effect of cocaine is systemic effect, a through-the-body effect, and that is a blocking of the reuptake of norepinephrine and also to some degree stimulating the release of norepinephrine.

Q. And norepinephrine is?

A. Norepinephrine is known in the vernacular as adrenaline, a hormone, a systemic hormone released by the adrenal gland which tends to stimulate increased heart rate, increased blood pressure, increased reflexes, decreased appetite, gets rid of a need for sleep, so people don't sleep and they don't eat and they're all jazzed up. And the rush of cocaine, the -- what's described as the initial rush of cocaine, is a norepinephrine or adrenaline surge.

The third effect of cocaine is a central effect in the central nervous system where cocaine blocks the reuptake of dopamine and it also stimulates the release of dopamine. Dopamine is a neurotransmitter.

Q. A neurotransmitter is what?

A. A neurotransmitter -- a neurotransmitter is a chemical

release by one nerve or neuron in the brain which then stimulates a second nerve or neuron in the brain and produces a reaction or a feeling. And dopamine is the -- is the neurotransmitter which produces euphoria in the human brain. For example, on the first sunny, warm day in spring, if we were able to measure dopamine levels in our brain compared to the last snowy, cold day in February, all of our dopamine levels would be a little higher because our spirits would be a little higher because of that external stimuli.

Q. Spring fever actually has a physiological effect?

A. Clearly. Absolutely. Dopamine is deficient, or the brain is relatively immune to normal levels of dopamine when people have clinical depression and, therefore, most antidepressant medications work either directly or indirectly to intensify the brain's sensitivity to dopamine so that our spirits are lifted and the depression eases. Dopamine honestly is released during any pleasurable experience.

Cocaine is the most potent drug that's been identified which blocks the reuptake and stimulates the release of large amounts of dopamine in the brain, and, hence, it produces variant euphoria. So, pretty much all addictive drugs that we know of, from nicotine to marijuana, from heroin to cocaine, including things like alcohol and Valium and even prescription pain medications, all either directly or indirectly increase dopamine levels in the brain. Dopamine

is clearly a final, common pathway of addictive drugs.
Q. Now, Dr. Parran, what I'm going to ask you is this question: Based on all of the materials you were provided which you reviewed in connection with this matter, and drawing on your professional experience and knowledge, do you have an opinion, to a reasonable degree of medical certainty, whether Mr. Hicks was cocaine- or chemically dependent at the time he committed the offenses in question?
A. Yes, he certainly was cocaine dependent and alcohol dependent and, hence, he had chemical dependence with a drug of choice, of cocaine, and a secondary drug of choice, of alcohol -- that would be the current terminology we use clinically.
Q. You described how the cocaine affects an individual pharmacologically; correct?
A. (Nods head affirmatively.)
Q. Could you tell us what cocaine psychosis is?
A. Yes. I just described the sort of three pharmacological effects of a single dose of cocaine: Peripheral nerve numbing, of how the drug was administered, and then sort of systemic rush of a surge of norepinephrine, and then central release of dopamine and euphoria. That's what happens when anyone takes a single dose of cocaine.
As people take more and more cocaine, as people repetitively administer cocaine, several things happen: Less

and less dopamine is released because the dopamine nerves in the brain only have a certain supply. Since the cocaine stimulates too much release of dopamine and doesn't let the nerve take it back up to recycle it, the nerve becomes depleted of dopamine and, hence, subsequent administrations of the drug produce lower and lower amounts of euphoria. At the same time when the drug wears off, people have what is called dysphoria, or a hangover. It's almost better to grasp --

Q. Is it easier to chart that?

A. The euphoria -- it would be easier to draw it out.

MR. MEZIBOV: Your Honor, may I use the chart?

THE COURT: We'll recess and he can draw his diagram.

MR. MEZIBOV: Thank you, Judge.

THE CLERK: All rise.

(At 10:12 a.m., a brief recess was taken.)

* * * (10:35 a.m.)

THE COURT: Is the petitioner ready to proceed?

MR. MEZIBOV: Yes.

THE COURT: Respondent ready to proceed?

MR. WILLE: Yes.

THE COURT: Proceed.

BY MR. MEZIBOV:

Q. Dr. Parran, during the break you have prepared a couple

of exhibits for us; have you not?

A. Yes, I have.

Q. And we were talking about cocaine psychosis and the pharmacological effects of that.

A. Yes.

Q. Could you, with the Court's permission, come down and show us what you prepared for us?

A. Okay.

THE COURT: Proceed.

MR. MEZIBOV: Your Honor, with your permission. Maybe if we all came closer. Is it okay?

THE COURT: I can see.

MR. MEZIBOV: Okay.

(Witness positioned by the easel.)

A. What I've tried to graph out here is the effects that one might receive from the administration of a fixed dose of cocaine by two different routes.

What I've drawn in a solid line here, sort of this wavy shape, is the effect that one might receive from snorting or intranasally administering perhaps 10 milligrams of cocaine.

And along this axis here is sort of a person's mental state, base line, euphoria and dysphoria, and at the bottom end of dysphoria, paranoia.

And what I've drawn along this axis is time.

If a person snorts, for example, 10 milligrams of

cocaine, it takes about two minutes for a person to really start getting high. It's because cocaine is fairly slowly absorbed across the nose membrane and there isn't very much membrane in the nose to absorb it.

Also, we mentioned that one of cocaine's initial effects is to produce a lot of norepinephrine in the system, a lot of adrenaline in the system, and that causes a spasm of smooth muscles which closes down blood vessels. So, there isn't much blood to the nose when one snorts, so the cocaine is slowly absorbed. The peak euphoria is after 20 minutes. The total duration of euphoria is 40 minutes, possibly a little longer, possibly a little shorter, and then there is dysphoria, there is a hangover. And as with any mood-altering drug that a human self-administers, the euphoria is always followed by dysphoria. It doesn't matter if it is alcohol or nicotine or cocaine. And the intensity of the low is pretty directly proportional to the intensity of the high, to use the example of alcohol that many people are more familiar with. How intoxicated a person gets is proportional to their hangover. And it'd take approximately the same time to come back to base line from dysphoria to euphoria, that is, if you snort cocaine.

THE COURT: So the episode is 80 minutes?

THE WITNESS: Eighty minutes from snorting cocaine, yes. When you look at this kind of a curve, you see a curve

that actually resembles having a mixed drink at a party. A person, after a little while, gradually becomes a little disinhibited (sic) or euphoric. It wears off after a period of time with dysphoria and a person comes back to base line.

If you take those same 10 milligrams of cocaine, instead of administering intranasally, if you use it in an I.V. or if you smoke it -- it is just that the cocaine that was available in 1985 generally was cocaine hydrochloride, the acid form of cocaine, it was not smokeable. Cocaine carbonate (phonetic) or base, so-called freebase, is crack cocaine. This is what's marketed now and it is easily smokeable by changing it from its acid to base form, which most people cocaine dependent smoke it. Back in '85, most people with cocaine dependence couldn't turn cocaine hydrochloride into cocaine chlorate (phonetic) and smoke it, so they tended to use it in an I.V. And if you take the 10 milligrams of cocaine, if I had drawn it proportionally, this area below this curve here should be equal to the area under this curve here because it's the same 10 milligrams of cocaine. But what happens is this onset of the high begins in 15 to 30 seconds instead of two minutes.

THE COURT: That is I.V.?

THE WITNESS: I.V., or smoking. But for purposes of this discussion, I.V. It begins in 15 seconds; takes about that long for blood circulation to move through the arm

to the inferior vena cava to the lungs to the brain. It peaks at about two minutes. It is pretty much done, in terms of the measurable or reported euphoria, within about ten minutes, and then there is a very deep dysphoria that follows the very high euphoria, and then much more gradually the dysphoria comes back to base line.

Q. What is the impact or the dysphoria with respect to the paranoia that you've also outlined on the chart?

A. Well, if a person uses a small amount of cocaine I.V., they get very intensively euphoric for a short period of time and then their actual mood, their spirits -- this is what is called dysphoria, depression, despondency, lack of interest in anything in life, except perhaps using more cocaine is what sort of dysphoria would be defined as. And if the dysphoria gets deep enough, people tend to repetitively report paranoid ideation, paranoid feelings, and that will become more important when I show you the next graph which demonstrates multiple self-administered doses of cocaine.

The reason why I said if a person shifts to an I.V. form of cocaine from a snorting form of cocaine that it indicates to me addiction, is that when a person is this high, this is not a "social high." The high is so intense at this point that the human brain has a tough time processing other stimuli. When a person is this intoxicated, it's often considered a so-called social lubricant. When a person is

this intoxicated, it probably doesn't matter to the person whether they are at a party or isolated. It's just tough to interpret much else here. And then the low is so low, the hangover is so intense, that most social users of the drug, whatever that drug may be, if they're used to do doing this and they ever do this kind of intense experience with the drug, they say "This is too high. This is too low. The whole thing was gone too quick. I'll never do that again."

When a person has the disease of addiction, this is interpreted, this intense high is interpreted as Nirvana. And this intense low, by some strange neurochemical mechanism of addiction that we don't -- that we haven't identified yet, this intense low is actually interpreted by the addicted brain as a reason to use again now, which is the difference between social users of mood-altering substances and people with chemical dependency. It is clearly a brain lesion. It is clearly a disease of neurochemistry. But we don't know why this -- what would be a called a negative reinforcer, a reason not to do that behavior again -- is interpreted in the addicted brain as a reason to use now.

Q. Before we turn the chart, for purposes of the record we'll indicate that Dr. Parran has signed his name and initialed his first chart. We've marked that as Exhibit 15.

A. Seeing this sort of basic pharmacology of cocaine, sort of regardless of chemical dependency or not, this is the same

graph --

(New chart displayed.)

A. -- that typifies a cocaine binge or a person who repeatedly self-administers cocaine by the I.V. route, as is evidenced in this case.

Q. This is again marked Exhibit 16 and bears your initials and the date.

A. Yes. Yes. What happens is that the initial use of the cocaine produces an intense euphoria that goes away relatively shortly; but the dysphoria lasts a long time. The dysphoria tends to produce in a person with an addiction an overpowering urge to use again. And so they use again, but this time the place where they start from is actually at a low level, as opposed to a normal base line.

THE COURT: I'm sorry. This is your addict? Is this your addict? Are we dealing now with an addict?

THE WITNESS: Yes. A person with addiction, yes.

THE COURT: All right. And you say "a long time." How long?

THE WITNESS: The dysphoria after a single administration of cocaine can certainly last -- can certainly last 80 minutes.

THE COURT: Well, now on the other chart it was a short time, you told me.

THE WITNESS: The dysphoria peaks soon, but it has

a gradual tail.

THE COURT: But now you're changing it. You had it about 50 or 60 minutes, and now you're changing to 80 minutes. Aren't you?

THE WITNESS: Well, this is the dysphoria, or the -- or the intense low that people feel. They gradually come back to base line, but the craving for more cocaine is described to last -- to last significantly longer than that. But this is actually the low mood state, and this is 60 minutes, 50 minutes, somewhere in that range.

THE COURT: I'm just using your charts now.

THE WITNESS: Okay. That's fine.

THE COURT: So, the line, the diagonal line that you were just talking with before I interrupted you --

THE WITNESS: Yes.

THE COURT: -- is a 60- to 80 minute line?

THE WITNESS: Certainly an hour.

THE COURT: All right.

THE WITNESS: Certainly an hour.

THE COURT: So in Mr. Hicks' case, we're dealing now with the first hour?

THE WITNESS: This would be the first self-administration, so it would be about the first hour.

THE COURT: So the euphoria was felt again -- before the euphoria was felt again, we're dealing with an

hour of time?

THE WITNESS: I'd have to go back and look through the notes for exactly the period of time that was reported, but it's -- it's my recollection now that the first administration took place, and then within -- between an hour and two hours the second administration took place. And then once again there is some differing reports of between three and five injections; about an hour or so, maybe two hours, with a third injection, yes.

THE COURT: Proceed.

THE WITNESS: Okay.

A. (Continuing) What will typically happen in a cocaine binge is a person will use cocaine, they'll feel high, they'll feel very low. They'll grad -- their spirits will be very low here. They'll self-administer again sometime. When they self-administer again, the peak of the high is significantly lower than the initial, partly because they're starting from a lower base line state when they use again, but partly because there isn't as much dopamine in the original nerve as there was in the first place because so much was released in the initial -- in the initial use of the drug. And so you're dealing with a functionally dopamine-depleted nerve and, hence, it can't release as much dopamine. So, with the second administration, people never report being anywhere near as high as with the first

administration, and always report that the low is much lower than after the first administration.

So, if we have a second administration, at some point during that same binge, honestly these administrations in some cocaine binges are every 15 to 20 minutes. Sometimes they're spaced out by a few to several hours. Usually it's in the range --

THE COURT: When do they become fatal?

THE WITNESS: Cocaine -- cocaine binges actually are surprisingly rarely fatal, considering we have about three million people intermittently binging on cocaine per year in the United States. We only have about somewhere between a thousand and 1500 fatal overdoses from cocaine per year.

THE COURT: How much -- how much does that take? Or does it vary with the size of the individual? Or is it something that can be -- can't be determined except on a case-by-case basis?

THE WITNESS: It is a case-by-case basis. The reason being, because the fatality of cocaine tends to involve one of three mechanisms -- actually four; the most common I'll get to last. The first is spasm of the coronary arteries, smooth muscle in the arteries in the heart which spasm lead to a heart attack and then death. And that is just sort of an intermittent thing that is unpredictable.

Secondly, a seizure. And it's entirely unpredictable when a person can have a seizure associated with cocaine use.

Thirdly, rarely will people have a stroke from cocaine use, and it can be a large stroke and produce death. The most common way that cocaine produces death is suicide, and there's lots of suicides as well as homicides associated with this sort of bizarre paranoid behavior that begins when people are in the midst of a binge. We don't have good numbers on that. The numbers that I gave you of about 1500 people a year, maybe 2000, who die of cocaine overdoses are from heart attacks, seizures or strokes.

THE COURT: And you say that cocaine base leads to this episode that you've just described in Exhibit 16 more than just powder cocaine?

THE WITNESS: Actually, cocaine hydrochloride, powdered cocaine and cocaine base, rock cocaine or crack cocaine, are pharmaceutically the same thing. It's -- it's just that in order to get enough cocaine hydrochloride, the powdered cocaine, into one's system to experience this, it really has to be used in an I.V., and most Americans are terrified of needles and won't use an I.V. Cocaine base is pharmaceutically identical. It is just if you smoke cocaine, it is all instantly absorbed by the lung. The nicotine companies have known that any mood-altering substance that

can be volatilized or vaporized and, hence, inhaled, can be instantly absorbed by the lung and, hence, delivered pretty much directly to the brain, and so it's two different delivery systems for really, honestly, the same drug.

THE COURT: And it's only cocaine base that can be delivered to the lung?

THE WITNESS: Yes. Cocaine hydrochloride, powdered cocaine. If you heat it, you have to heat it to 400 degrees centigrade for it to burn, and then it actually burns and denatures, rather than vaporizes. Cocaine chlorate -- or what we know as crack cocaine, rock cocaine or base -- if you heat it, since it's in the base form, it vaporizes at a hundred degrees centigrade; temperature that is easy to reach in, you know, any sort of smokeable form. And, hence, since it volatilizes and vaporizes, it is able to be smoked, inhaled in the lungs and absorbed directly by the lungs, much like nicotine. And the -- I hate to say it, but the advantage -- but the advantage of delivering a mood-altering drug to the brain by the lung is that it's all absorbed into the lung immediately in a very small -- one heartbeat's worth of blood, when then in the next heartbeat it gets delivered to the left heart, which then in the next heartbeat is delivered to the brain. So, we're really talking from the time you smoke cocaine it is -- from the time you inhaled to the time the cocaine hits your brain is, for all practical

purposes, three to four heartbeats, and so it's an even quicker, more concentrated way to deliver a boulis of the drug to the brain, hence, it tends to, if anything, be even a little bit more reinforcing with even a little bit more acute onset and possibly a higher peak than using an I.V.

THE COURT: So, the use of cocaine base is more likely to result in an episode that you've described on Exhibit 16 than the use of cocaine hydrochloride?

THE WITNESS: The use of cocaine base is just as likely to produce this kind of a binging situation (indicating) as the use of cocaine hydrochloride I.V. And the use of cocaine hydrochloride by snorting, the intranasal route, tends to be less likely to produce this kind of a phenomenon.

THE COURT: And this episode you say results in violence or death?

THE WITNESS: Well, yes.

THE COURT: Violence against self, violence against others?

THE WITNESS: Especially with subsequent self-administrations. Each time a person uses, the high is less high and the low is even more low. With more and more dysphoria, more and more paranoia, more and more intrusive thoughts, more and more difficulty interpreting normal stimuli as being non-threatening. It tends to lead to people

arming themselves on often a regular basis, using more and more by themselves, being more paranoid in their ideation, misinterpreting external cues and participating in what everyone else would observe as unprovoked random violence.

THE COURT: As a practical matter, a user of cocaine -- "addict," if you will -- the only way they can use it or assimilate it is by self-administration; isn't it? There is only one to administer to?

THE WITNESS: No, I've interviewed lots of patients with positive toxicology tests for cocaine, all of which are certain someone slipped it in their drink. And when the story comes out, that doesn't happen.

THE COURT: Proceed. I'm sorry.

THE WITNESS: No. The important aspect with this kind of a graph is that as people in the midst of a binge with cocaine, repetitive self-administration of cocaine, as they become more and more dysphoric, the paranoia and then more clearly psychotic symptoms of cocaine psychosis become prominent. The estimates are that when people use cocaine I.V. or they smoke it, and if they use it in an intermittent binge crack pattern, the estimates are at least 50 percent and probably 70 percent of people develop significant paranoid ideation during the end -- during binges after the initiation, or binges lasting for a few to several hours after the end of a binge; 50 to 70 percent. One would say,

"Well, if this drug produces euphoria first and then all of this terrible dysphoria and more and more paranoia and after a while a person is using and not getting back to base line, why on earth do people continue to use it?" -- that is addiction. If I had an answer to that, it would be even simpler to treat people.

The paranoia, sort of the continuum from dysphoria to paranoia to psychosis with cocaine -- and it honestly is a continuum, almost like a continuum of white to black with many shades of gray in between -- is one which has clearly been identified and honestly was identified back in the early '80s as a phenomenon which was susceptible to something called the "kindling effect." And let me just describe the kindling effect and then I'll stop and answer questions, I guess.

The kindling effect was first identified in manic depressive disease or so-called bipolar disease, where it was observed that if a person had manic depressive disease, when they first developed it, their manic episodes would last a long time and not be real manic and they're depressive episodes would last a long time and not be very depressed. And as a person went through the cycling of manic depressive disease, it required less stimulation of a mania to bring upon a more and more intense depression and then less stimulation of a depression to bring on more an more intense

mania. And it seemed that person seemed to cycle more and more rapidly between mania and depression and it's been hypothesized as an electrical phenomenon in the brain called the Kindling phenomena.

It was next demonstrated in the early '60s in Lexington, Kentucky at the Addiction Research Center at the Federal Penitentiary for Drug Offenders that the Kindling phenomenon was clearly present in opium dependents. The way that they studied this is, they basically took federal prison volunteers who had a history of opium dependence and they gave them morphine for six weeks -- six times a day by injection and then they put them in a small room with bizarre wallpaper for five days and let them go through untreated withdrawal. And they took -- and morphine withdrawal lasts for five days. Then they'd take them out of that room and put them back in prison for six months with no morphine, and they would bring them back and just put them back in the room with bizarre wallpaper without any morphine, and 100 out of 100 patients would develop dilated pupils, runny noses, objective and substantive signs and symptoms of opiate withdrawal just being in the context where they had been in previously untreated withdrawal before. Sort of a Pavlovian learned response, one might say.

What was demonstrated in research in the late '70s and the early '80s with cocaine psychosis and with

cocaine-associated seizures is that clearly a kindling phenomenon is present with cocaine as well, especially in the area of cocaine-associated paranoia, cocaine-associated psychosis and cocaine-associated seizures. The earliest research was with the seizure in the late 1970s. They identified people tended not to have a cocaine-associated seizure unless they had been on an extensive binge, tremendous quantities of cocaine, a couple thousand dollars worth of cocaine on a weekend, and then they would finally surpass the level of cocaine toxicity in their system where they would have a seizure. And once they had that one seizure, subsequent use of cocaine to a much lower level -- just two or three or four administrations of cocaine -- could produce a seizure in the same person, where previously it had required 20 or 30 self-administrations. Once the wiring mechanism or the response of a seizure to cocaine intoxication had happened in those people's brains, it took less of an insult from the drug to produce the same effect.

What was then identified in the early 1980s is that it was exactly the same with cocaine-associated paranoia and cocaine psychosis. Then originally when people began using cocaine in an addictive way, it required a lot of cocaine, a heavy, heavy binge maybe for a day and -- a day or two days for a person to really start getting toxic from a paranoid and sort of psychotic delusional standpoint. But once they

had reached that, subsequently -- even if they had been off cocaine for six months or a year -- subsequently only a couple, three, four, five administrations of cocaine could produce similar paranoid and psychotic symptoms, a kindling phenomena, which was identified in the literature in the early '80s -- clearly in the early '80s but also in -- associated with amphetamine psychosis, and cocaine is scheduled as an amphetamine-like drug. The kindling phenomenon with amphetamine psychosis has been well known since the 1950s. I'll stop.

Q. Dr. Parran, I'm going to ask you to resume your seat, if you would.

(Witness regained the witness stand.)

Q. Dr. Parran, you've mentioned three central features, I believe, in this discussion here: One is cocaine psychosis; two is this concept of binging; and third is that of the concept of kindling, kindling effect.

Could you relate all of those concepts or phenomena with the history of John Hicks as you understood it from the materials that you were provided?

A. Yes. Certainly Mr. Hicks, his past history over the last three to four years prior to the crimes that were committed, demonstrated an intermittent binge-type dependence or addiction on cocaine. His pattern clearly was a binging-type pattern where he wouldn't use it for several days, often

several weeks; occasionally a few to several months. But then once he did use, he'd use repetitively and then try to stop it. And once -- once he had used, he used repetitively on that occasion and then he stopped it, but he'd only be able to be stopped for a short period of time and then he was repetitively again. Sort of a gradually accelerating intermittent binge pattern. Periods between binges got shorter and shorter. That certainly is what he described in his interview with Dr. Baum in 1990 and it is what he described to some degree in his interview with Ms. Leahy.

And certainly the descriptions that Mr. Hicks gave to Ms. Leahy as well as the detectives in Knoxville when they interviewed indicated there was a cocaine binge that he had -- that the events of August 4th or 5th, I can't remember which date it was, had the hallmarks of a binge: Hadn't used for a while, pay day, got paid, got his money, all of his plans for the day went out the window; used cocaine -- actually initially had a little bit of trouble getting the initial cocaine and started getting edgy and restless and irritable, used the cocaine, felt very high. As it went away, he got increasingly crescendo urgings or cravings to use more cocaine, again began to cast about on how to get money for more cocaine, et cetera. So, it's -- it's classic for a cocaine binge.

The paranoia, moving towards cocaine psychosis, is

actually there's some evidence in the interview done in Knoxville with the detectives that supports there being paranoia, intrusive thoughts, difficulty following through and maintaining one thought pattern, erratic, irrational, and uncharacteristic out-of-control behavior on his part is all there. Even in the interview it was concluded by people, you know, who will -- who are law enforcement professionals, not clinicians -- had clinicians been conducting that interview, I think several points would have been followed up on and a lot more data in the interview, but, I think there is clearly some data there and then much more data in the interview done by Ms. Leahy about the mental state or the thinking state, psychological state that Mr. Hicks was in after or during this binge of cocaine.

And then the kindling phenomenon also is -- there's some evidence for the kindling phenomenon in Mr. Hicks' history in the assessment done by Dr. Baum, the really good chemical dependency evaluation done by Dr. Baum in 1990, as well as some in Ms. Leahy's interview indicating previous sort of binging patterns and suspiciousness and paranoid ideation in the past when he had used the cocaine -- much more heavily in the past than at this time. So, I think there is evidence of all of that.

Q. Now, let me ask you -- let me ask you some ultimate opinions in a moment. But before I do, in looking through

paranoia comes on after the intoxication has worn off, when the dysphoria has kicked in, and it tends to get worse and worse with subsequent administrations. So, the dysphoria paranoia and psychosis tends to increase with subsequent administrations, whereas the intoxication tends to decrease with subsequent administrations.

And clearly the literature, both now and in the early 1980s, indicates that once this severe paranoia or cocaine psychosis begins, it tends to last for a matter of hours after the last administration of cocaine. It rarely, if ever -- and, frankly, lasts up until the time of the crash. What I teach medical student residents -- honestly, what I teach Emergency Room doctors, I have many talks about the cocaine-intoxicated and cocaine-agitated person. What I especially tell Emergency Room doctors, because they're the ones that see people in this state all the time, is when a person has been binging on cocaine, they're getting more and more agitated, paranoid, irritable, interpreting external stimuli as threats. They frequently also are experiencing tightness in the chest, chest pain, other things, so they often wind up in the Emergency Room. And when they come in, they're very dangerous and they need to be sedated immediately in order to -- in order to ensure the safety of the Emergency Room staff. Once -- what tends to happen is a person binges on cocaine for a certain period of time and then there is a

peri-binge period of a few hours, several hours. People are restless, irritable, paranoid, and then they crash. And the crash means basically going to sleep and sleeping it off and eating a lot, because in the midst of a binge, the norepinephrine effects of cocaine cause people not to eat and not to sleep. So, the recovery -- the crash from cocaine tends to involve hypersomnolence and hyperphasia: Eating a lot of things and sleeping a lot.

Rarely -- in fact, clinically it is almost unheard of now -- people still have some cocaine psychosis after they wake up at the end of the crash. Very, very rarely. But, typically, a fair number of people are paranoid right up until the time of the crash, of the time when they fall asleep.

When we look at -- at this case and we hear the descriptions of a single use, strong cravings to use more, hocking a VCR, erratic thoughts, commission of a murder, use of more cocaine, commission of another murder and sort of agitated period of time where a person is hypervigilant, goes home, sees their spouse, used some sedating drugs -- people frequently self-treat that agitated, restless time with things such as marijuana or alcohol, sedatives which were self-administered, and then leaving, driving, still being sort of irrational, crashing, going to sleep, waking up and driving to the police station and turning one's self in and

confessing, is classic for cocaine psychosis.

Q. Now, I think you've answered in a substantial way my next question, but let me ask you anyways: What are the outside signs and symptoms of cocaine psychosis?

A. Let me add -- I'll list a few things and then I'll specifically list a few things that are not described with cocaine psychosis which I think have shown up in some of the transcripts as confusing points. Cocaine psychosis, or -- cocaine psychosis is a phenomenon which is characterized by paranoid thoughts, misperceptions, intrusive thoughts. So the feeling, like thoughts are coming into one's head, suddenly having a thought, frequently irrational, intrusive thoughts, hallucinations, overwhelmingly tend to be either auditory, hearing voices -- although they're usually interpreted as thoughts as coming in their mind -- but hearing voices and tactile -- occasionally people feel what is called cocaine fleas, or feel things crawling on their skin, less and less ability to follow consistently through on a plan, more jumping and jumping from one plan to another and from one thought to another and more and more bizarre ways.

What typically is not present with cocaine psychosis is florid delirium. I mean, these people aren't talking out of their minds, acting, you know, bizarrely, schizophrenic or talking like they're in delirium or DTs, or whatever, but their thoughts and their behaviors are erratic and irrational

and frequently moving from being mildly paranoid, to being armed, to being actually violent.

Q. Now, were these classic signs and symptoms of cocaine psychosis present in the record that you have reviewed relating to Mr. Hicks?

A. Yes. I think as I mentioned there's evidence of it even in the interview with the detectives in Knoxville, although that interview was an interview aimed at an entirely different topic. I mean, it was a difficult task. Even given the fact it was, you know, a law enforcement, professional interview, there is evidence in that interview that some of this was going on, and a lot of evidence in the interview done with Ms. Leahy.

Q. And, Dr. Parran, do you have an opinion, to a reasonable degree of medical certainty, whether Mr. Hicks was in the throes of a cocaine psychosis at the time of these two murders?

A. Yes, I -- in reading the -- having read the transcript from the confession and having read the history of the client in terms of the past, my initial opinion and my overwhelming opinion since then is that from a clinical standpoint, if I had to create a differential diagnosis, my differential diagnosis in this case would be cocaine psychosis, cocaine psychosis, cocaine psychosis, cocaine psychosis, and then maybe something else, but I can't imagine what else it would

be.

Q. What were the indicia, if you will, of cocaine psychosis that you observed in the record as surrounding the murder of these two individuals?

A. What would be the addition?

Q. The indicia, the indications that Mr. Hicks was in the throes of cocaine psychosis when these two murders were committed.

A. I can -- I can open up the transcript and give you a couple specific examples --

Q. That would be helpful.

A. -- if you like.

The first I'll mention is the transcript from the Knoxville Police Department, and this transcript on its second page -- or on the first page, it says, "I went over to this guy's house that I knew and had some cocaine. So I bought me some." And then there's some information about the person he bought it from, and then "I used it and some after I went home and then that craving came, you know, to get some more dope. So what I did, I called the man and asked if he had some for me. He said okay. So I took the VCR we had at the home. So I went over there, and a little bit later I gave it to him, so he gave me some more. So I told him I would pay him back tomorrow. I realize I didn't have the money to get the video recorder because it wasn't mine, so I

got to thinking -- I said I've got to do something, you know, because the video recorder didn't belong to me. I knew there'd be a lot of bullshit going on with my wife, so what I did, I got to thinking well, since I'm supposed to have went to the ball game -- well, I didn't. Okay? So I called her" and he was calling his mother-in-law.

Those sorts of things, indicating sort of the person buys some cocaine, doesn't have any more money, is moving toward a cocaine binge regularly and routinely, hocks about anything they have that's valuable in order to get some more cocaine, and then once that's been done, frequently tries to figure out how to get some more money, it becomes more and more irrational.

So, "I need some more money. Maybe I should go rob my mother-in-law." That's entirely irrational, compared to robbing someone else who doesn't know you, who you would knock over the head and would never recognize you. That is crazy. But this man isn't crazy. This man does haven't a history of schizophrenia. He doesn't have a history of serious mental illness. That is an indication there of cocaine psychosis.

He states on the next page, "But getting back to where I was just going to leave," he said to the detective he was just going to leave the apartment, and then -- "So she was wondering about that cage and what the bird cage had in it

and blah, blah, blah. She turned around and I just grabbed her and started strangling her." That once again sounds like, you know, sort of the erratic sort of impulsive behavior of a person who's getting more and more sort of psychotic on a cocaine binge.

A little further on they talk about finding a gun. He said -- the interviewer said, "You could not find the gun?" And the defendant said, "Yeah, at first, then all of a sudden I realized that. I said, well, you know, Brandy knew I was the last one here, so, you know, it was like I was, 'No, I shouldn't do that to her,' you know." That sounds very much to me -- giving a law enforcement interview as opposed to a clinical interview -- of a person describing intrusive thoughts that are coming in that are bizarre and completely irrational sort of, you know, coming into a person's mind.

"And so, after I got the money, I said 'I'll leave and come back and clean up this mess.' So I called the man and I finally caught up with him." I think that -- "...finally caught up with him." In the interview with Shirley Lehmann (sic) later on, he talks about how he couldn't call the person, there was no answer on the phone, the phone was busy, he was pacing around the apartment, more and more edgy, irrational, and dashed out and got more cocaine and came back here and used cocaine right here in the same place. Despite having already gotten the money and gun and everything else

is -- is -- clearly the most likely clinical explanation is cocaine psychosis.

So, he went and got some more cocaine. "And then must have been around 12:30, something like that, I went on ahead and shot up the dope. I got -- I got a 50-cent piece and all of a sudden I got to thinking again" -- "I got to thinking again," just typical cocaine psychosis and shortly thereafter intrusive thoughts, "I started thinking again well, I'd better go ahead and do this because she's going to be the only" -- referring to Brandy, and so, you know, he committed the second murder.

Q. Well, is that evidence of rational thinking, to cover up a crime, or does it reflect something else in your clinical opinion?

A. All of it -- I mean, from -- from the trying to figure out how to unhock the VCR on is some of the most bizarre and irrational thought patterns that one can imagine, or at least that I can imagine, and indicates more and more paranoia and bizarre behavior and is quite indicative of cocaine psychosis.

Later, it says "It was in the living room, but I dragged it to the bedroom" -- which is Maxine's body. "...then I got to thinking I need to do something with it before someone discovered it, so I was going to cut her in half and put her in the freezer, and all of sudden I did and then I stopped."

I mean, that is crazy. That is not the actions of a person who is -- whatever. And then --

THE COURT: You used the term "crazy," Dr. Parran. Could you relate that to the opinions you've expressed about cocaine and psychosis?

THE WITNESS: I'm using the vernacular "crazy," that is, bizarre thoughts and actions of a person who is -- who is clinically most likely involved in a cocaine psychosis given a past history of no mental illness.

A. (Continuing) And then finally on the next page there talking about the sexual abuse of the girl: First, you know, I was thinking all weird. Thinking all weird." Here's a person, a day later even, describing his own thoughts of, you know, thinking all weird, and so those are the evidences in the police report.

And then it takes some time, but reading through the report from Ms. Leahy, there's what I consider to be just much more data from a trained clinician interviewing about these issues, asking followup questions about "What do you mean 'thinking all weird'? What kind of thoughts were you having?" -- and those sorts of things.

Q. Based on the information you were able to obtain from the record, your conversations with Mr. Hicks and any other materials that you were provided, do you have an opinion, to a reasonable degree of medical certainty, as to the duration

of the cocaine psychosis which you've just testified about?

A. The -- my best clinical judgment would be that the cocaine psychosis and -- that the cocaine psychosis certainly continued through the time that Mr. Hicks went home to his -- his and his wife's apartment. Probably until the time that he drove out of town and maybe until the time he actually went to sleep in Knoxville.

Q. Let me ask you this question --

THE COURT: When did it start?

Q. That was my next question, the onset. In your opinion, to a reasonable degree of medical certainty, what was the onset of this cocaine psychosis?

A. The onset was probably shortly after the second self-administration of cocaine; the cocaine that was used -- the cocaine that was bought with the VCR.

Q. Now, Dr. Parran, in your professional opinion, were the Court and the jury properly and accurately informed through the testimony of the witnesses who were presented at trial as to the nature and extent of Mr. Hicks' cocaine dependency and psychosis at the time he committed these acts?

A. No.

Q. And why is that?

A. It's clear from my reading of the transcript that the information that was provided about cocaine pharmacology was inaccurate during the trial; that the information given

regarding the timing of -- the difference between cocaine intoxication and the cocaine psychosis was not entirely but largely inaccurate, and that the information that was given about the signs and symptoms of cocaine psychosis were substantially inaccurate. The information given regarding the expected onset of cocaine psychosis, based upon the timing of the use of the drug, was inaccurate, as well as the expected duration of cocaine psychosis. That also was inaccurate. And, finally, the idea that cocaine psychosis was more likely to happen in a person who was a chronic, daily user of cocaine with day in and day out cocaine use, which is actually very rare for people to actually do that but even more rare for people who have cocaine psychosis, but that was entirely inaccurate.

Q. Dr. Parran, if you're able to do so, are you able to refer to portions of the record in which you feel that there were substantial inaccuracies or errors with respect to the information that was provided to the Court and the jury concerning Mr. Hicks' cocaine --

A. Sure.

Q. -- situation?

A. Sure. And I'll do it in whichever way is usually most appropriate in these settings. I can give the page and -- the page number and the line number.

Q. Are you able to pinpoint who the witness is?

A. If you want me to read the statement --

Q. If you could summarize perhaps what the statements are, but also if you could indicate which witness is providing this inaccurate information to the jury.

A. Okay. The primary information which was inaccurate was provided in the testimony of Nancy Schmidtgoessling, and her testimony started on Page 1175. The areas where the inaccuracies were most notable is on Page 1178 -- I'm sorry 1187, where they talk about the difference between snorting cocaine and using cocaine I.V. And Dr. Schmidtgoessling gave clearly wrong information from Line 22 on that page through Line 6 on Page 1188. The information -- should I read the information, or just --

Q. If you could summarize it.

A. Okay. Well, it basically said that that cocaine goes into the bloodstream faster if you snort it than if you use it I.V., which is wrong. She says that the intensity of the symptoms of the intoxication of cocaine are equal, whether you used an I.V. or snort it, which is clearly wrong. And she said that the reaction would be -- that the only difference between using cocaine nasally versus I.V. is that the reaction might be quicker nasally rather than I.V., and it is not the only difference and, in fact, that's wrong.

Then on Page 1191, starting at Line 11, they talked about the levels of intoxication from cocaine being similar to the

levels of alcohol, various degrees of intoxication. And the question -- or the response of the expert was that they were similar; that, you know, there were sort of a linear intoxication effect from cocaine similar to alcohol, which is -- which is not the case. Cocaine has much too short a half life to be able to look at levels of intoxication.

Then at the top of the next page on 1192, the question was would cocaine be the same curve of dysfunction? Can the effect and degree of one's ability to perform depend upon the amount that a person took in? -- meaning if you only took in a little cocaine now, it will have a little effect, and if you took a lot of cocaine, it will have a lot of effect. And the expert said "Yes," definitely demonstrating no evidence of the knowledge of the kindling phenomena that we talked about before where one has activated kindling with cocaine addiction. Even reasonably small amounts of the drug can precipitate in large behavior, rational changes.

Page 1193, the description of why people die from cocaine: "In fact, when people die of cocaine overdose, it is usually from a respiratory problem." Virtually no one dies of a cocaine overdose from a respiratory problem. It is a seizure, stroke or heart attack. It has little to do with the lung.

She then points out later on that page that this patient -- or this defendant was able to retain his orientation and

his goal directedness and, therefore, he was not significantly affected by cocaine when he was committing the crimes. As I described earlier, it is in the literature, and in the 1980s, in the literature now, when a person is involved in cocaine psychosis, they are oriented, they know who they are, and where they are, and when it is. They are oriented to person, time and place. They are nct delirious and they frequently follow through with impulsive actions, although they tend not to be able to follow through in a single plan of action over an extended period of time.

And then, finally, throughout this entire section, all of the statements were about the -- about whether he was intoxicated at the time, not whether there was the dysphoria and the paranoia and cocaine psychosis.

There's just a couple more here. On Page 1195, starting at line 18, the question is:

"Let's talk about that. This stuff reaches a peak in fifteen to twenty minutes."

And the response from the witness was...

"Yes, that is customarily thought to be the peak."

Well, that certainly is not when you're using I.V. cocaine. It is gone in ten.

The question then was...

"Then the person returns to normal later

rapidly?"

And the response was...

"Yes, usually sort of a crash, as they refer to it. It usually takes ten to fifteen minutes."

Actually, the crash is, after a binge, often a few hours after a binge, which tends to last proportional to the length of the binge.

"Question: The whole thing is less than half an hour?"

"Answer: Not if there is something mixed in, but, yes."

"Question: Doctor, did you actually" --

I'm sorry, the next page, 1196, pretty close to the end...

"Doctor, did you actually make an examination of the life background as part of your history to determine his work record, the way he dealt with his peers and so forth?"

"Yes, I did."

"Question: Did you see anything in there that indicated either cocaine usage or chronic usage of cocaine?"

And the answer on Page 1197 reads...

"I didn't see anything as far as chronic usage. He was regular to work, he was cooperative with his co-workers, he was a good employee and reliable."

All of that information, given a history of binging on several thousand dollars of cocaine a few years earlier, a couple thousand dollars use of cocaine six months earlier, and given the history of a person who went to work and participated normally in working during the day and wound up committing two murders and other things later during the night, is absolutely diagnostic of cocaine addiction and cocaine psychosis, and her statement is that is that it's no indication of chronic use. I think -- I think that's it.

Q. Dr. Parran, in your professional opinion, based on the information that was presented at trial and which you've just commented on, do you believe the jury was fairly and accurately apprised of the effects of cocaine on Mr. Hicks' conduct that night?

A. Absolutely not.

Q. Okay. For the reasons you've stated?

A. Yes.

Q. Now, Dr. Parran, this case took place in 1985; that's when the trial took place. What was the current state of medical knowledge of cocaine and cocaine psychosis at that time?

A. Well, that's a very good question. Certainly we know more about cocaine now than we knew in 1985 and 1986, but that's because we've experienced our current cocaine epidemic which started honestly in probably 1976. But we've

experienced it for another decade since then. But in 1985 and '86 -- and I think the trial actually took place in February of '86 -- cocaine addiction was well-known. It was in the DSM-III, and then subsequently published a little later in 1986, the DSM-III-R, and now in 1995 the DSM-IV, cocaine psychosis and stimulant psychosis. Amphetamine psychosis has been described in the literature since the 1950s. In fact, there are a few descriptions later in the Western European literature, the German literature from the 1930s, of paranoid ideation and bizarre behavior from cocaine.

But what would be most available to practitioners in our community in Ohio in 1985 are several articles from well-respected psychiatric journals and widely-read psychiatric journals from the mid- to late-'70s right up until 1986, and certainly since. They talk about cocaine psychosis, paranoia associated with cocaine, these long last -- longer lasting effects of cocaine than just the mere intoxication.

Q. Dr. Parran, let me stop you there and ask if I might hand you an exhibit, Plaintiff's Exhibit 17.

Could you identify that exhibit for us, please?

A. Yes, it's a face sheet or a Xeroxed copy of a face sheet of a list of articles in the medical literature, that I wrote down the initial or the earliest one being in 1931, the last

one being in 1986, early 1986 -- I think published in February of 1986 -- basically listing articles in the medical literature about cocaine dependence, cocaine addiction, including references and descriptions of cocaine paranoia, cocaine psychosis.

Q. So what Exhibit 17 is, is a compendium or a list of the articles?

A. The first page is a list and attached are the actual articles.

Q. And these are examples of the type of materials that were available to practitioners by February of 1986?

A. Absolutely, yes.

Q. Is there anything about which you have testified this morning relating to cocaine, cocaine psychosis, the kindling effect, the binging, the psychosis, the paranoia, the duration of cocaine psychosis which would not have been available to practitioners in this field in 1985 and 1986?

A. In general, no. There is one -- I did cite one piece -- one statistic where it's thought that 50 to 70 percent of people who -- who use cocaine in a binge-crash pattern experience clinically significant paranoid ideation, with better than half of them actually arming themselves with weapons during cocaine binges, and that was published after 1986.

But the description of the kindling phenomenon with

cocaine psychosis, as well as cocaine seizures, the description of the typical binge-crash pattern and the description of cocaine psychosis itself and cocaine paranoia coming on after the intoxication of cocaine and lasting well beyond the intoxication of cocaine are all very well documented in the medical literature in 1985, '86 and before.

Q. And to your knowledge, Dr. Parran, was that information and examples of that literature available to practitioners in that field of addiction in Cincinnati, Ohio in 1985 and 1986?

A. Oh, absolutely. One of the articles is from the American Journal of Psychiatry, the most widely distributed, widely read journal, psychiatric journal in the country, and that is from March of 1975 and its titled is "Cocaine Psychosis: A Continuum Model."

There is an article from 1976 in the same journal, the American Journal of Psychiatry, and the title is "Cocaine, Kindling, and Psychosis." That was a decade before these events.

And then I have a few here, one in 1986 "Neuroleptic Reduction of Cocaine-Induced Paranoia" in the Journal of psychopharmacology published in February of 1986, the same month of the trial. Even the Psychiatric Annals in 1984 -- the psychiatric annals are very widely distributed -- have articles describing -- describing the same thing.

MR. MEZIBOV: Your Honor, if I may have one minute,

that may be it.

(Messrs. Mezibov and Lazarow conferred privately.)

Q. Two final questions, Doctor. First, with respect to this information and the availability of these materials as an extension of that question, were there, and to your knowledge, practitioners in the field which you study and about which these articles have been written who were available in Cincinnati to have this information at their disposal?

A. Well, certainly there were in the early 1980s. The Cincinnati V. A. has a big Addiction Medicine Treatment Program that was active then. They had a specific drug treatment branch, as well as a separate alcohol treatment branch. They treated them separately then. We're now treating them together with a psychiatrist as well as internists on their staff. In fact, the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse, two branches of NIH in 1980 developed a career teacher's program where they supported individuals of medical schools to acquire more education and then teach about addiction and the pharmacology of addictive drugs. And Don Nelson, who is a clinical pharmacologist at the University of Cincinnati, was a career teacher with NIAAA and NIDA from 1981, and was teaching a pharmacology course at the University of Cincinnati Medical School on drugs of abuse in

the '80s and is still there now.

Q. Dr. Parran, you also mentioned there was a study that evaluated or reported on the violence associated with cocaine psychosis, people being armed and the like. What is the correlation between cocaine psychosis and violent behavior?

A. The study that was reported, they studied a couple of hundred people who used cocaine in a binge, binge-crash kind of pattern, either smoking it or using it I.V. Seventy percent reported clinically significant paranoid ideation happening around the time of cocaine binges. The -- 50 percent of those who had paranoid ideation reported that the paranoid ideation lasted all the way through to the time of the crash, so it lasted for a few to several hours after the cessation of the cocaine use. Better than half of people with paranoid ideation reported that they had intermittently armed themselves during a cocaine binge with various weapons. And of that 50 percent who had armed themselves, a quarter reported having actually been violent. None reported actually ever having killed someone, but a quarter reported having been violent, including jumping out of windows because they were sure the police were coming through the door; beating up a significant other because -- thinking they were sending messages about the person using cocaine to law enforcement; misperceiving external stimuli and then reacting in a violent, arming way.

If you remember, norepinepherine adrenaline is the hormone which produces our fight or flight response. People, when they're overstimulated with norepinepherine, tend to get more and more paranoid, have more and more tough time focusing on something and tend to be hyper-reflexic, and really sort of armed. It's -- it's a hormone which -- which has tremendous survival benefits for humans; but when overstimulated with it, people can be very violent.

Q. The facts that you found in the record in Mr. Hicks' case, they're consistent with the findings of these studies you've just mentioned with respect to violence?

A. Yes.

MR. MEZIBOV: That's all the questions I have of this witness. Thank you, Doctor.

THE COURT: Doctor, in your history that you accumulated on Mr. Hicks, was there a history of seizures?

THE WITNESS: No, there was no history in his case of cocaine-associated seizures and that sort of kindling phenomenon. Just a kindling phenomenon in terms of the paranoid thoughts as such.

THE COURT: Can an addict that has become an intermittent binge-type pattern individual, can that addict reasonably be expected to overcome the addiction?

THE WITNESS: I couldn't give you worthwhile information in 1985 because the epidemic was too early at

that point. But at this point, I think we have some pretty good information, and the information that we have now is that if you take a thousand people with cocaine addiction, intermittent binging, whether they're smoking it or using it I.V., and you follow them up over 15 years or so, at the end of 15 years, better than a third of them will be sober and in stable recovery. Of the ones that survive -- because there is a highly fatal condition here -- that a third will be sober, in stable recovery, about another third will have switched to a different pattern of drug use, and that's honestly what we're seeing in Ohio now: People are switching to heroin since cocaine has sort of a short life; people are switching to mixing cocaine with heroin. They get jazzed up on the first use of cocaine, feel very -- euphoria. And when the dysphoria of the cocaine should be kicking in, that is when the sort of euphoric period, the mellow high of the heroin kicks in. And instead of going on a full-blown binge, a person tends to use cocaine and heroin together twice a day.

So, we've seen, sadly, about a third of our addicted patients, who normally were bingers on cocaine, just switch pharmacologically to a different approach but still be out of control with chemical dependence.

And, finally, another third are either incarcerated or dead.

THE COURT: So, it's reasonable to believe that approximately a third could be sober?

THE WITNESS: If -- if people escape either death or jail, the statistics are that 50 percent of the people, whether they have alcoholism or cocaine dependence, over time will eventually get sober and stay sober for outstanding periods of time.

THE COURT: Does the snorting of cocaine have any detrimental effect on those membranes and so forth? Is that permanent?

THE WITNESS: That can be permanent. It's probably not the cocaine itself that damages the nasal membrane, but what happens is when a person snorts cocaine, when the norepinepherine is released, there's spasm of the smooth muscle and the blood vessels that go in the nose, so people stop absorbing it. The nasal septum is made of cartilage and cartilage doesn't have its own blood supply. It depends on blood vessels to passively supply oxygen to the cartilage. And so, cartilage is exquisitely sensitive to not enough blood supply, and so what happens is actually the cartilage in the septum dies and deteriorates and falls out. To cite a famous example, Linda Ronstadt had cocaine addiction and was afraid of needles and didn't know how to turn it into freebase, so she just snorted and snorted and lost her nasal septum, went into treatment and had to have a nasal septum

replaced several years later by a plastic surgeon so she could sing again.

THE COURT: Did you conduct any physical examination of Mr. Hicks?

THE WITNESS: No.

THE COURT: Wouldn't that be medically prudent to help you make your opinion here today?

THE WITNESS: It may have been, although it was ten years after the fact.

THE COURT: Well -- well, I prefaced my question: Is it permanent --

THE WITNESS: The physical --

THE COURT: -- and you agreed.

THE WITNESS: The permanent signs I'd look at, that if I had thought of that, would honestly be from track marks, from I.V. marks.

THE COURT: You didn't see the I.V. track marks?

THE WITNESS: No.

THE COURT: They would still exist?

THE WITNESS: Track marks would probably exist, although the disclaimer that I would give you is that track marks in people who are opiate dependent tend to be much more chronic and long lasting, because people tend to use opiates in a chronic pattern. People tend to do intermittent binging on cocaine. They tend not to use the same vein, and so the

track marks tend to be much less permanent scars with cocaine use.

THE COURT: Did you examine, in reaching your opinion, any criminal history of Mr. Hicks?

THE WITNESS: Very superficially. I read one of the background psychological reports that talked about his history of domestic violence in the past while intoxicated. I didn't read that extremely carefully.

THE COURT: You don't know of any specific crime or criminal experiences with the law other than domestic violence?

THE WITNESS: At least based on my memory right now it was a domestic violence incident and a court-mandated outpatient counseling program in '82, I think.

THE COURT: Any other history which was not significant in your opinion?

THE WITNESS: Well, when I interviewed him myself and when I quickly looked through the past psychological record, I was looking for evidence of previous psychotic behavior, behavior that would indicate any mental illness or the behavior that indicated extreme violence, and all I saw was the domestic violence.

THE COURT: Thank you, Doctor. We'll recess until 1:15. 1:15. Thank you, Doctor.

THE WITNESS: You're welcome.

THE CLERK: All rise.

(At which time, the luncheon recess was taken.)

* * *

AFTERNOON SESSION (1:31 p.m.)

THE COURT: Is the petitioner ready to proceed?

MR. MEZIBOV: We are, Your Honor.

THE COURT: Respondent ready to proceed?

MR. WILLE: Yes, Your Honor.

THE COURT: Doctor, I believe you're on the stand. Proceed, Mr. Wille.

MR. WILLE: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. WILLE:

Q. Doctor Parran, have you ever testified at trial in a capital case?

A. No, sir.

Q. Have you ever testified in a criminal case involving cocaine as an issue?

A. No.

Q. Are you familiar with the factors set forth in Ohio law as to mitigation with respect to a capital offense?

A. No, I'm not.

Q. Now, you are not a psychologist or a psychiatrist; is that correct?

A. That is correct.

Q. Now, are you aware that Dr. Schmidtgoessling rendered an opinion in conjunction with this case that Mr. Hicks at one point had been feigning the symptoms of mental illness?

You're aware of her opinion in that regard?

A. Yes.

Q. Now, I take it -- or would you consider yourself to be competent, qualified to render an opinion as to the validity of her opinion in the latter regard?

A. I can certainly give you my opinion about that as an internist and a physician.

Q. Would you consider yourself to be an expert with respect to -- I'll withdraw that.

Would you offer an expert opinion as to the validity of her expert opinion?

A. I would not offer it regarding her opinion of his diagnosis of malingering or feigned mental illness.

Q. And that's what my question was directed to --

A. Okay.

Q. -- if I was not clear on that.

Now, Dr. Parran, would you think that you are qualified to render an opinion as to whether a person is suffering from a mental disease or defect?

A. I'm certainly qualified to render an opinion, but as a non-psychiatrist, I would probably not be considered qualified to render an expert opinion.

Q. Now, Dr. Parran, am I correct you did speak with Mr. Hicks?

A. Yes, I did.

Q. And you mentioned in direct testimony that you were, I guess, I don't know how you put it, but you were looking forward to the opportunity to speak with Mr. Hicks in the sense of the experience of doing so?

A. No, I wouldn't -- I wouldn't -- I wouldn't say that. I did think that it was important for me to have a chance to talk to Mr. Hicks once I had looked through the materials that had been forwarded to me and was -- and was at the place of beginning to form an opinion about cocaine psychosis.

Q. Would it be fair to say that your experience is somewhat limited in talking with persons who have been convicted of serious felonies?

A. Yes.

Q. And I take it -- it may seem to be an obvious question, but I take it you've never interviewed before someone who had been convicted of murder and sentenced to death?

A. I have interviewed people who been convicted of murder in the past, but no one who has been sentenced to death.

Q. Now, Dr. Parran, in forming your opinion with respect to Mr. Hicks, I take it that you gave weight to what he told you during the interview?

A. Yes.

Q. And now, Dr. Parran, in normally -- in normally dealing with persons with cocaine psychosis, do you on occasion rely on such things as, say, urinalysis tests or blood tests?

A. Yes; not -- not as it relates to cocaine psychosis, but as it relates to documentation of cocaine use.

Q. Now, Dr. Parran, you've testified that you assisted with the training of interns with respect to handling persons in emergency situations. Is that a fair statement?

A. Yes.

Q. And I take it that in that circumstance you would be dealing with a situation where the person that may be suffering from a cocaine psychosis is right before you at the critical time, if you know what I mean?

A. Yes.

Q. So, I take it then that you would consider that to be a very important thing to consider, namely the opportunity to actually observe the person under -- appear or under the possibility -- strike that -- actually observe the person in the highly agitated state which would be consistent with cocaine psychosis?

A. Certainly the people who observe patients the most when patients are actively involved in a state of cocaine psychosis are people who work in Emergency Rooms, ambulances, intake offices, those sorts of things.

Q. Would you say you're one of those persons?

A. I certainly have done a lot of consultations in Emergency Rooms, yes.

Q. Have you -- in your function as a consultant, would you

say that -- I take it you have actually seen people that appear to be under the symptoms of a cocaine psychosis?

A. Yes.

Q. And in this particular case, however, you've never seen Mr. Hicks under --

A. No.

Q. -- apparent influence of a cocaine psychosis?

A. No.

Q. Now, Dr. Parran, are you aware or have you reviewed Dr. Hawgood's report with respect to Mr. Hicks?

A. I'm sure that I have because I'm -- I think it was in the materials that I looked at, yes.

Q. If I were to represent to you that during an interview with Dr. Hawgood Mr. Hicks admitted that at one point he feigned the symptoms of mental illness, that would -- that would be consistent with your recollection of Dr. Hawgood's report?

A. Yes, as well as Dr. Schmidtgoessling's opinion.

Q. Exactly. And would it be -- or do you recall that in the course of her report, Dr. Hawgood indicated that Mr. Hicks stated that he had been advised by certain jailhouse lawyers to feign these symptoms of mental illness because it might be beneficial to his case? That would be consistent with your recollection as to her --

A. Yes, I think it was multiple personality disorder, or

something like that.

Q. If I were to tell you that Dr. Hawgood testified in a deposition in this case that in fact Mr. Hicks had indicated to her that "Yes, I -- I did feign some mental illness because I was advised by jailhouse lawyers," that would be consistent with your recollection of --

A. Uh-huh.

Q. -- your review of that deposition?

A. Yes.

Q. Now, would it be fair to say, Dr. Parran, that in that circumstance Mr. Hicks appeared to be willing to tell Dr. Hawgood a falsehood -- strike that.

Would it appear, based on Dr. Hawgood's statements, that Mr. Hicks had occasion to lie because he thought it would help his case?

A. Yes.

Q. Now, have you considered the possibility that when Mr. Hicks described his cocaine use to you, that perhaps he was entertaining the same intent to lie?

A. Yes; I must -- that's certainly a possibility that I've thought about, and thought about at the time I interviewed him. I must say that the majority of my opinion is based upon the data in the interview with the detectives in Knoxville and based upon information and, secondarily, based on information in the interview with Ms. Leahy, I think in

September of '85, both of which, at least to my review, appear to have taken place prior to much of the other behavior that Mr. Hicks demonstrated with other examiners.

Q. Would you be -- are you aware that Mr. Hicks demonstrated some aberrant and bizarre behavior to Mrs. Leahy?

A. The second -- the second day, the second interview day, yes.

Q. And are you also aware that after Mrs. Leahy's interview with Mr. Hicks, that Mr. Hicks expressed similar -- or showed similar behavior in his interview with Dr. Schmidtgoessling?

A. Yes. My impression was that his initial interview with Ms. Leahy was an extended interview in which he appeared to be giving consistent information which anticipated to be reasonably backed up with interviews with other family members and the second interview was much more bizarre. And from there on, the interviews were -- were difficult.

Q. Now, Dr. Parran, you have examined, I take it, much of the information that Mrs. Leahy gathered?

A. Yes, I think I read the report entirely.

Q. Are you aware or do you recall that at one point Mr. Hicks himself stated in the course of Dr. Schmidtgoessling's investigation as to his sanity that he, in fact, did not abuse cocaine or alcohol?

A. Yes.

Q. And would it be fair to say, Dr. Parran, that some of the

information cited by Mr. Hicks in support of his -- his allegation or assertion of cocaine psychosis was developed in State post-conviction proceedings? Would that be a fair recollection or statement as to your recollection of the record?

A. I have a problem with Mr. Hicks -- with the beginning part of your statement, because it was not my impression from reading any of the materials that Mr. Hicks claimed a cocaine psychosis.

Q. Are you familiar with the affidavit of Dr. Baum?

A. I'm familiar with Dr. Baum's affidavit, which was obtained in 1990.

Q. Yes. And, therefore, it was obtained -- you would have no reason to doubt it was obtained in conjunction with Mr. Hicks' post-conviction action; correct?

A. My understanding is that Dr. Baum's opinions were formed in 19 -- late 1989-90, after the conviction.

Q. And isn't it true that Dr. Baum relied on information in forming his opinion that was brought out following Mr. Hicks' conviction and during his post-conviction action?

A. Yes, with -- interviews with Mr. Hicks and others.

Q. So, it is then fair to say that at least in part your diagnosis is based on information which was developed subsequent to Mr. Hicks' conviction?

A. Certainly the information in Dr. Baum's evaluation of